



APPOINTMENT INFORMATION

Who recommended PT-OT Professionals for your care (circle):

Doctor / Self / Friend / Return / Advertising: _____ Other: _____

Date of Accident/Injury: ___/___/___ OR Date Symptoms Began: ___/___/___

Type of Accident: at work at home auto other (explain): _____

Name(s) of family, friends, or others we may communicate with regarding your treatment, appointments, prescriptions, test results, billing, and insurance questions, etc:

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ___ / ___ / ___ Social Security Number: _____ - _____ - _____ Marital Status: _____

Home Phone # _____ Cell Phone # _____ Email: _____

Employer: _____ Work Phone # _____

Spouse's Name: _____ Employer: _____

Work Phone # _____ Cell Phone # _____

Emergency Contact Person: _____ Relationship: _____

Home Phone # _____ Cell Phone # _____

PERSONAL HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Policy Holders Name: _____

DOB (required if other than patient): ___ / ___ / ___ Effective Date of Policy: ___ / ___ / ___

Policy # _____ Group # _____ Employer: _____

Insurance Claims Address: _____

Phone # _____ Patient's Relationship to Policy Holder: _____

Secondary Insurance: _____ Policy Holders Name: _____

DOB (required if other than patient): ___ / ___ / ___ Effective Date of Policy: ___ / ___ / ___

Policy # _____ Group # _____ Employer: _____

Insurance Claims Address: _____

Phone # _____ Patient's Relationship to Policy Holder: _____

PLEASE CONTINUE ON NEXT PAGE

MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION

(If your appointment is the result of an MVA)

Motor Vehicle Insurance: _____ Policy # _____ Claim # _____

Address: _____

Phone # _____ Contact Person: _____

WORKER'S COMPENSATION INSURANCE INFORMATION If your appointment is the result of a work related injury or workmen's compensation claim, please complete the information below. Your visit to our office must be authorized by the worker's compensation insurance carrier prior to your appointment or we may be required to reschedule your appointment.

Employer When Injured: _____ Phone # _____

Address: _____ Contact Person: _____

Worker's Compensation Insurer: _____ Contact Person: _____

Address: _____ Date of Injury: ____ / ____ / ____

Phone # _____ Claim # _____ State Where Injured: _____

Case Manager: _____ Phone # _____

If you have retained the services of an attorney in connection with your injury or illness please give the attorney's name, address, and phone number:

Attorney: _____ Phone # _____

Address: _____

GUARANTOR OF PAYMENT

(Please complete this section with parent for custodial information if the patient is a minor)

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ Social Security Number: _____ - _____ - _____ Marital Status: _____

Home Phone # _____ Cell Phone # _____ Email: _____

Employer: _____ Work Phone # _____

Spouse's Name: _____ Employer: _____

Work Phone # _____ Cell Phone # _____

PLEASE CONTINUE ON NEXT PAGE

AUTHORIZATION AND CONSENT

I CERTIFY THAT THE INFORMATION I HAVE FURNISHED ABOVE IS COMPLETE, TRUE, AND ACCURATE.

Signed: _____ Date: ____ / ____ / ____

Acceptance of Financial Responsibility and Assignment of Benefits: I hereby authorize payment of benefits on my behalf by my insurance plan or any government sponsored plan directly to PT-OT Professionals. I understand that, if the providers at PT-OT Professionals are not participating providers with my insurance plan, I am responsible for amounts determined ineligible by my insurance plan due to its "maximum allowable" or other internal payment policies. I agree to pay any co-pays, deductibles, or co-insurances that are my responsibility under my insurance plan(s). I understand that I will be billed and held responsible for my account regardless of the status of any insurance claim(s). Interest charges of 1.5% per month will be charged on all outstanding patient balances over 30 days. I have read, had my questions answered, and agree to comply with this statement.

Signed: _____ Date: ____ / ____ / ____

Consent for Treatment: I hereby consent to such medical treatment, including evaluation, diagnosis, treatment or care, as ordered by my physician or other licensed provider for myself or for the patient for whom I am the parent or authorized representative. I acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment I receive.

Signed: _____ Date: ____ / ____ / ____

Authorization to Release Protected Health Information: I hereby authorize PT-OT Professionals to use or disclose my protected health information and/or other information to treat me, for requests by other health care providers involved in my continued or future treatment, to determine benefits, to authorize payment, and to process claims for payment. I further request and authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information required to process my claim(s) or to provide continued or future treatment.

Signed: _____ Date: ____ / ____ / ____