Clinic Name: Sportfit Physical Therapy

PATIENT INFORMATION

NAME: ________ SOCIAL SECURITY #: ________

ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ________

HOME PHONE: ________ MOBILE: ________ WORK PHONE: ________ EXT: ____

DATE OF BIRTH: ________ MARITAL STATUS: ________ PATIENT SEX: ________

PERSON TO CONTACT IN CASE OF EMERGENCY: ________

RELATIONSHIP: ________ PHONE: ________

REFERRING PHYSICIAN: ________ PHONE: ________

DATE OF INJURY OR SURGERY: ________ DIAGNOSIS: ________

CAUSE OF COMPLAINT DUE TO: ☐ AUTO ☐ WORK ☐ OTHER ________

INSURANCE INFORMATION Do you have a secondary insurance? ☐ Yes ☐ NO

PRIMARY

NAME OF INSURANCE COMPANY: ________

BILLING ADDRESS: ________

PHONE: ________ REPRESENTATIVE: ________

POLICY/ID#: ________ GROUP#: ________ EFFECTIVE DATE: ________

BENEFITS: ________ % DEDUCTIBLE: ________ MET: ________ COPAY: ________ OUT OF POCKET MAX: ________

REQUIRES PRE-AUTH: ☐ Yes ☐ No AUTH #: ________ # OF VISITS AUTHORIZED: ________

AUTHORIZED BY: ________ DATE: ________ PLAN LIMITATIONS: ________

SECONDARY

NAME OF INSURANCE COMPANY: ________ PHONE NUMBER: ________

INSURANCE BILLING ADDRESS: ________

POLICY HOLDER: ________ RELATIONSHIP TO PATIENT: ________

SOCIAL SECURITY/MEMBER ID #: ________ GROUP #: ________

WORKERS' COMPENSATION / AUTO INFORMATION

NAME OF INSURANCE COMPANY: ________ PHONE #: ________

ADDRESS TO SUBMIT CLAIMS: ________

ADJUSTER: ________ PHONE #: ________ FAX #: ________

DATE OF INJURY: ________ CLAIM #: ________ PREVIOUS PT/OT (This Injury) ☐ Yes ☐ No

EMPLOYER: ________ PHONE #: ________

AUTO PATIENTS ONLY: POLICY HOLDER: ________ RELATIONSHIP: ________

AUTO POLICY #: ________ MED-PAY ON POLICY: ☐ Yes ☐ No AMOUNT: $ ________

MEDICARE PATIENTS ONLY

DO YOU HAVE MEDICARE PART A & PART B? ☐ Yes ☐ No

HAVE YOU RECEIVED HOME HEALTH WITHIN THE LAST 2 MONTHS? ☐ Yes ☐ No

ARE YOU CURRENTLY RECEIVING ANY TYPE OF THERAPY AT ANOTHER FACILITY OR HOSPITAL? ☐ Yes ☐ No

HAVE YOU PREVIOUSLY RECEIVED PT/OT/ FOR THIS DIAGNOSIS? ☐ Yes ☐ No

TRICARE/TRIWEST PATIENTS ONLY

ARE YOU CURRENTLY AN ACTIVE MEMBER IN THE SERVICE? ☐ Yes ☐ No

Cancellation Policy: 24 hour notice is required for all cancellations and/or appointments that need to be rescheduled. An answering machine is available for your convenience during non working hours. Appointment cancellations with inadequate notice or (2) "no shows" will result in the cancellation of all remaining appointments, discharge from therapy and a notification of non-compliance to your referring physician.

Consent For Treatment: I consent to have PRN and/or its affiliates to provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

Financial Responsibility and Assignment of Medical Benefits: I hereby give authorization for payment and/or insurance benefits to be made directly to PRN Physical Therapy and/or its affiliates for services rendered. I hereby authorize the release of any medical records and information, including statements of my account pertinent to my diagnosis, injury or illness, which are necessary to process this claim. I understand I am responsible to know my insurance benefits and inform the front desk staff of any changes in my insurance before services are rendered. Failure to provide change of insurance information may affect my coverage an/or authorization and may result in denial of claims for unauthorized services. I am aware that I am financially responsible for all charges not paid by my insurance company. PRN will bill your insurance company for services rendered. All co-pays and deductible are due at the time of service. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I further authorize that my signature on this form constitutes assignment of benefits to the above named health care provider.

________________________ PATIENT'S SIGNATURE

________________________ DATE