Patient Information

Patient Name _____ S.S.# ____-____-____
Mailing Address _____ Home Phone _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Marital Status S M O
Employer _____ Work Phone _____
Referring Doctor _____
Cell# _____

Insured Information

Insured Name _____ S.S. # ____-____-____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Date of Birth _____ Relationship to patient _____
Employer _____ Work Phone _____
Cell# _____

Primary Insurance

Insurance Co. _____ Co-Pay _____
Address _____ Phone _____
City _____ State _____ Zip _____
Policy # _____ Group # _____

Work related ? Yes No Claim# _____
Adjuster's # _____
Adjuster Name _____ Date of Injury _____

Secondary Insurance

Insurance Co _____ Co-Pay _____
Address _____ Phone _____
City _____ State _____ Zip _____
Policy # _____ Group # _____

Authorization

Insurance Assignment and Medical Records Release:

I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to ProRehab Physical Therapy, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-pay and/or deductible amounts., I, the undersigned, agree to pay all attorney fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue such matters. I further agree to pay interest in the amount of 1.5% per month on any balance over 90 days. I do hereby give my permission to ProRehab Physical Therapy to furnish my insurance carrier(s) any and all information pertaining to my medical records.

Signature: _____ Date: _____