PATIENT INFORMATION

CLINIC NAME: KELLY HAWKINS PHYSICAL THERAPY

RX DATE_____ SCHD APPT _____ TX START DATE _____ THERAPIST_____

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 _____ICD #_____

CAUSE OF COMPLAINT DUE TO: ❒ AUTO ❒ WORK ❒ OTHER_____

NAME OF INSURED/ POLICY HOLDER

NAME _____ RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY #_____

EMPLOYER NAME _____ PHONE _____DOB_____

INSURANCE INFORMATION Do you have secondary insurance? ❒ Yes ❒ No

PRIMARY

NAME OF INSURANCE COMPANY _____Date:_____

BILLING ADDRESS: _____TMJ Yes_____or No_____

PHONE ( )_____ - _____ REPRESENTATIVE _____Calendar Year Starts_____

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 #_____

INSURANCE BILLING ADDRESS: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT_____

SOCIAL SECURITY/ MEMBER ID# _____ GROUP#_____

WORKERS' COMPENSATION / AUTO INFORMATION / ATTORNEY 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

Insurance Benefits and Payment Policy: The information listed above is a description of your healthcare benefits, which was given to us by a representative of your health insurance company. It is not a guarantee or authorization of payment. Actual benefits cannot be determined until the claim has been received and processed by your insurance. We will call to verify your insurance coverage. Deductibles and co-payments are due at the time of service.

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to the above name healthcare provider.

I consent to have this healthcare provider and/or its' affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

_____ _____

PATIENT'S SIGNATURE DATE