



Patient Name:	Account #:
Home Address	Home Phone:
City:	Alternate Phone:
Patient SSN:	DOB:
Email:	Referring Physician:
Insurance Provider:	Insurance ID:
Name of Insured/Responsible Party:	Insured's SSN:
Employer:	Insured's DOB:

Signature Required

If my insurance carrier denies payment for any reason, I am aware that I am financially responsible for payment of all services rendered.

Signature of Patient or Responsible Party *Date*

Patient, Please Note: If this is an accident or work-related injury, and it is to be billed under 'No-Fault' or 'Worker's Compensation Insurance', Please provide all necessary information at your initial visit. Without this information we will have to bill you directly. Thank You.

For Office Use

<input type="checkbox"/> WCB	WCB Claim:
Number of Visits:	Number of Weeks:
Plan Type: <input type="checkbox"/> PPO In-Network	<input type="checkbox"/> Commercial Indemnity
Deductible Amount:	<input type="checkbox"/> Remaining balance: \$
Co-Pay for Office Visits: <input type="checkbox"/> No	Yes, Amount: \$
Representative's Name:	Direct Phone:
Claims Address:	Medicare Therapy Cap: 877 – 567 - 7173
	Deductible of: Has/Has not been met
	Total Applied to PT/OT:

Completed by: _____ **Date:** _____