

**PRN PHYSICAL THERAPY**

**PATIENT INFORMATION**

*Clinic Name:* \_\_\_\_\_

**OFFICE** \_\_\_\_\_ **TREATMENT START DATE** \_\_\_\_\_ **THERAPIST** \_\_\_\_\_

NAME \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ DRIVER LICENSE # \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_  
OCCUPATION/POSITION \_\_\_\_\_  
PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

REFERING PHYSICIAN \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_ ICD# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

PVT	WC	MEDICARE	AUTO	LIEN	CASH	HMO	PTPN	OTHER
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**PRIMARY**  
NAME OF INSURANCE COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ CLAIMS ADJUSTER: \_\_\_\_\_ AUTH # \_\_\_\_\_  
POLICY/ID # \_\_\_\_\_ GROUP/CLAIM# \_\_\_\_\_ HOME CARE: YES / NO  
DATE OF INJURY \_\_\_\_\_ PREVIOUS PT (THIS INJURY) YES / NO # OF VISITS \_\_\_\_\_  
NAME OF INSURED/POLICY HOLDER  
NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
EFFECTIVE DATE OF COVERAGE \_\_\_\_\_ DEDUCTIBLE \$ \_\_\_\_\_ MET \$ \_\_\_\_\_ COPAY \$ \_\_\_\_\_  
BENEFITS \_\_\_\_\_ % TO PAY OUT OF POCKET \_\_\_\_\_ PLAN LIMITATIONS \_\_\_\_\_  
AUTHORIZED BY \_\_\_\_\_ DATE \_\_\_\_\_ # OF VISITS AUTHORIZED \_\_\_\_\_

**SECONDARY**  
NAME OF INSURANCE COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ Policy ID # \_\_\_\_\_ Group Claim # \_\_\_\_\_

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates 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 hereby authorize this health care provider to release all information necessary to secure the payment of benefits. 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 this 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.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE