PRO CARE PHYSICAL THERAPY GROUP P.C.

PLEASE FILL OUT THE INFORMATION AS COMPLETELY AS POSSIBLE.

Date: _____

Name of Doctor's Office: _____

What type of insurance does the patient have?

Please mark one of the following:

Worker's Compensation ◯ **No Fault** ◯ **Major Medical** ◯ **Self-Pay** ◯

Patient Information: *(all information in this box must be filled out in order to properly process your claim)*
Patient Name: _____Gender: M F S.S.# ___-__-___D.O.B.: __/__/__
Address: _____City: _____ State: _____ Zip Code: _____
Home Phone: (____)____-_____ Mobile Phone: (____)____-_____
Work Phone: (____)____-_____
Emergency Contact: _____ Relation: _____
Emergency #: (___)___-____

Please fill in one of the following according to your Insurance:

Major Medical Insurance Information: *(please provide us with your insurance card(s))*
Name of Insurance:_____ Policy Holder: _____
I.D.#: _____ Group #: _____
Relationship to Patient: Self / Spouse / Child
If policy holder is other than self please provide D.O.B. ___/___/___ and
S.S. #: ____-___-_____

Secondary Insurance Information:
Name of Insurance: _____ I.D.#: _____
Group#: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____. And Assign directly to PRO CARE PHYSICAL THERAPY GROUP P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____X_____X_____

Responsible Party Signature Relationship to Patient Date

Medicare Authorization and Assignment (Medicare Patient Only)

I, request that payment of authorized Medicare benefits be made to PRO CARE PHYSICAL THERAPY GROUP P.C. for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

X_____X_____X_____

Responsible Party Signature Relationship Date

Very Important! To Be Completed At FIRST VISIT!

Was the policy in effect at the time accident (service)? (yes) (no)
Is there a deductible? (yes) (no) What is it $_____.
Has it been met? (yes) (no) Is there a co-pay? $_____
Is a referral needed in order to treat patient? (yes) (no) If yes do we have one? (yes) (no)
Address to where we should mail the medical bills:

_____
What is the coverage for P.T.? _____

If insurance policy or claim # are not in effect at the time of service, explain below and immediately inform the Doctor and Attorney.

Initials for person responsible for placing this information into the system _____ Date: _____
Initials for person responsible for verifying all the above insurance information _____ Date: _____

Employer Information: *(if accident happened while in course of employment)*
Company Name: _____
Address: _____City: _____ State:_____ Zip Code:_____
Phone #: (____)____-_____ Supervisor's Name: _____

No Fault Information:
Claim #: _____
Policy#: _____
Date of Accident: ____/____/____
Policy Holder: _____

Worker's Compensation Information:
Carrier Case #: _____
W.C.B. #: _____
Carrier Code: _____
Date of Accident: ___/___/___

Attorney Information: *(if applicable)*
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: (____)____-_____ Fax #: (____)____-_____