

SportsCare Physical Therapy, PC

Date of call _____ Receptionist _____ Appt. date/time _____

Name _____ Date of Birth _____ SS# _____

Address _____

Home Phone _____ Cell Phone _____ Email address _____

M S W D Spouse _____ If Child, Parents Names _____

Emergency contact _____ Relationship to patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Present Employer Name/Address _____ Work Phone _____

Occupation _____ Employment Status _____

Referring MD _____ Phone _____ PCP _____ Phone _____

Diagnosis _____

Was this the result of a car accident or work related injury? _____ Date of accident _____

Did you have previous physical therapy this year? _____ If yes, how many visits _____

How did you hear about us: Patient _____ YB _____ Exterior Sign _____ MD Referral _____ Insurance Plan _____

NF WC MC HMO PPO SP

PRIMARY INSURANCE:

Name _____ Address _____ Phone _____

ID# _____ Grp# _____ Subscriber _____ DOB: _____

Subscriber SS# _____ Relationship to patient _____

Employer Name/Address/Phone _____

SECONDARY INSURANCE:

Name _____ Address _____ Phone _____

ID# _____ Grp# _____ Subscriber _____ DOB: _____

Subscriber SS# _____ Relationship to patient _____

Employer Name/Address/Phone _____

WORKERS COMP/NO FAULT INSURANCE:

Name _____

Address _____ Phone _____ Fax _____

WCB# _____ Carrier Case # _____ File/Claim# _____

Policy # _____ Policy Holder _____ Claim Rep _____

Employer at time of accident _____

Attorney Name/Address/Phone _____

I authorize SportsCare Physical Therapy, PC to release any information to my insurance company that is necessary to expedite the payment of my claims. I understand that I am responsible for all charges not covered by my insurance including co-payments, co-insurance and deductibles. I understand that if my account is placed in collection, I am responsible for any and all fees associated with being placed into collection and legal proceedings. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions when appropriate and that if said referrals are not obtained, I am responsible for the charges not covered under the referral. I authorize benefits to be paid to SportsCare Physical Therapy, PC. I authorize SportsCare Physical Therapy, PC to contact the insurance commissioner on my behalf. In the event that my workers compensation or no fault claim is denied, I will make arrangements with SportsCare Physical Therapy, PC to be paid by my private insurance and/or myself.

Patient Signature (or Signature of Parent or Guardian) _____ Date _____