Patient Information Form

Date of Call/Registration: **Past Patient ☐Yes ☐ No**	**Patient Account Number:**

Patient Information verified DL/photo i.d:. ☐ Yes ☐ No

Last Name/Suffix	First Name		Middle Initial
Address:	City	State:	Zip Code:
Home Phone	Other Phone (Cell)	Email Address	
Date of Birth	SSN	Sex: ☐ M ☐ F	Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Employer Information

Employer Name:	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student		
Address:	City	State:	Zip Code:
Work Phone Number	Patient Occupation		

Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Physician Information

Name of Referring Physician:	Telephone #:	RX Date:_____ Eval/Treat: ☐ # of visits:_____

Additional Questions

Date of Injury Onset Date	Auto Related: ☐ Yes-State? _____ ☐ No **Adjuster name: _____** **Phone #:_____**	Work Related: ☐ Yes ☐ No	Accident Related: ☐ Yes ☐ No	Diagnosis/Body Part

Post Surgical: ☐ Yes / ☐ No / ☐ Unknown Surgery Date (if applicable): _____	Surgery Description: _____
Have you any prior Therapy this year? ☐ Yes ☐ No (PT/OT/SP or Chiropractic)	How did you hear about us?

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Service? ☐ Yes ☐ No If yes, Name of Agency ? _____
If Yes, what type of Home Health Services are you receiving? _____ Last Date of Service_____

If Medicare, have you received PT, OT or Speech services since the first of the year? ☐ Yes ☐ No

- If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No
- Are you aware of any partial amount used since the first of the year? $_____.
- If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Appointment Date:	Time:	Therapist:

Intake Completed By: _____ Date:_____	**Patient, Please initial here if the above information is complete and correct _____Date:_____**

Patient Name: Account Number:

Insurance Information

Only complete the following if the Primary or Secondary policy holder is not the patient. **Primary** ☐ **Secondary** ☐

Last Name:	First Name:	Middle Initial	SSN	DOB

Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other	Gender: ☐ Male ☐ Female
Employer Name:	Employer Phone #:

Primary Insurance Section		**Secondary Insurance Section** **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Child ☐ Other	
Payor/Plan Code:		Payor/Plan Code:	
Policy/ID #:	Group #:	Policy/ID #:	Group #:
Insurance Phone #:		Insurance Phone #:	
All Information Below "FOR OFFICE USE ONLY"		***All Information Below "FOR OFFICE USE ONLY"***	
Verification AT:_____ FSC:_____		***Verification***	
Date:	*Spoke with:*	*Date:*	*Spoke with:*
Verify Plan: _____ Effective Date: _____ *Is this a Federally Funded Plan? ☐Yes ☐ No*		*Verify Plan: _____ Effective Date: _____*	
Does patient have both PT and/or OT coverage? ☐Yes ☐ No		*Does patient have both PT and/or OT coverage? ☐Yes ☐ No*	
Informed Payor this is outpatient therapy performed in an office setting. ☐		*Informed Payor this is outpatient therapy performed in an office setting ☐*	
Visit Limitation:	*Coverage:*	*Visit Limitation:*	*Coverage:*
Limitations on Modalities or Units? *Home Program/97535___ Anodyne/97026 ___ Aquatic/97113___* *Other_____/_____ ____ Other_____/_____ ___*		*Limitations on Modalities or Units?* *Home Program/97535___ Anodyne/97026 __ Aquatic/97113___* *Other_____/_____ ____ Other_____/_____ ___*	
Comments/Special Instructions:		*Comments/Special Instructions:*	
Deductible: $ *Met: ☐Yes ☐No*	*Out Of Pocket: $* *Met: ☐Yes ☐No*	*Deductible: $* *Met: ☐Yes ☐No*	*Out Of Pocket: $* *Met: ☐Yes ☐No*
Does patient have a co-pay? ☐ Yes ☐ No If yes, amount: $ *Per Visit? ☐ IE/Re-eval only? ☐*		*Does patient have a co-pay? ☐ Yes ☐ No If yes, amount: $* *Per Visit? ☐ IE/Re-eval only? ☐*	
Required for therapy? ☐ Referral ☐ Authorization ☐ Pre-Cert *If any of the above is required, verify that it is on file? ☐*		*Required for therapy? ☐ Referral ☐ Authorization ☐ Pre-Cert* *If any of the above is required, verify that it is on file? ☐*	
Auth #:_____ # of Auth Visits:_____ *Auth Start Date:_____ Auth Exp Date: _____*		*Auth #:_____ # of Auth Visits:_____* *Auth Start Date:_____ Auth Exp Date: _____*	
Claims Address:		*Claims Address:*	

Verification (Workers Compensation)

Is this a State Funded ☐ or Self Insured plan ☐ (call employer) *Plan Name: _____*
Claim Number: _____ *Dx Codes on file: _____*
☐ *Allowed* ☐ *In Process* ☐ *Pending* ☐ *Hearing* ☐ *Other*

Adjuster Name:_____ Phone:_____ Fax:_____

Nurse/Case Manager Name: _____ Phone:_____ Fax:_____

Additional Notes:

Verified By:_____ Date:_____

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