

PATIENT INFORMATION SHEET

Therapist _____

Patient # _____

Date/Time of 1st Visit _____

REFERRED BY: Doctor Friend/Family _____ Ins Co Phone Book Other _____

Referring Doctor: _____ Injury/ICD-9: _____

Patient Name: _____ Birth Date: _____ Age _____

Address: _____ Phone#: _____

City: _____ State _____ Zip Code: _____ Work Phone#: _____

Cell Phone#: _____ E-Mail or other contact info: _____

Gender: M F Marital Status: _____

Patient Employed by _____

Employers Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT: In Case of Emergency Please Notify Spouse Parent Relative Friend

Name: _____ Phone _____

INSURANCE INFORMATION: HEALTH AUTO OTHER _____ WC CLAIM # _____

Responsible Party SELF SPOUSE PARENT/GUARDIAN OTHER DATE OF INJURY/SURGERY: _____

Insured Name: _____ Insured's Social Security # _____ Birth Date _____

Insurance Company _____ Insurance Phone # _____

ID # _____ Group # _____

INSURANCE VERIFICATION (OFFICE USE ONLY)

Effective Date: _____ Deductible _____ Has / Has not been met OOP Max _____ Lifetime Max _____

% Paid by Ins _____ % Due by Patient _____ Co-Pay _____ Amt Due Each Visit _____

Send Claims to _____

Visits Allowed _____ Precert Needed No Yes _____

Other PT Benefit Limits:

Authorization: _____ Verified by _____

CANCELLATION POLICY

We recommend that you schedule future appointments before you leave the clinic. We require Twenty-four hours notice to cancel appointments. There is a **\$75.00 charge for No Show and Appointments cancelled without 24-hour notice.** This is not covered by your insurance policy and will be your responsibility. **Initial**

CONSENT TO RELEASE MEDICAL INFORMATION, TREATMENT AND ASSIGNMENT OF BENEFITS:

I acknowledge that I have been offered a copy of Evergreen Sport & Spine P.T., P.C.'s Notice of Privacy Practices. I authorize Evergreen Sport & Spine P.T., P.C to release information to the physician and Insurance company named above. I authorize the release of information needed for payment of related medical claims. I permit a copy of this authorization to be used as the original. I consent to necessary physical therapy treatment by Evergreen Sport & Spine P.T., P.C as deemed necessary for the care of the above named patient. I understand that I am responsible for any charges not paid for by my insurance. I certify that I have provided accurate information.

Signature _____ **Date** _____ **Staff Init** _____

(Parent/Guardian if patient is under 18)



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