

Insurance Information

Insurance

Self-Pay

Workers Comp

Primary Insurance: _____ Phone #: _____

Claims Address: _____

Policy Holder: _____ DOB: _____ Relation to Policy Holder: _____

Employer: _____ Employer Phone #: _____

ID/Claim #: _____ Group #: _____

Secondary Insurance: _____ Phone #: _____

Claims Address: _____

Policy Holder: _____ DOB: _____ Relation to Policy Holder: _____

Employer: _____ Employer Phone #: _____

ID/Claim #: _____ Group #: _____

OFFICE USE ONLY- THIS SECTION WILL BE COMPLETED BY THE DOCTORS OF PHYSICAL THERAPY STAFF

This information is a quote of benefits given to our staff from your insurance company. **This is not a guarantee of payment**, and information reflected below may vary from your actual coverage. It is a patient's full responsibility to know all aspects of their policy and coverage.

Authorization Required: Y N **OrthoNet:** Y N **ACN:** Y N

Co-Pay: _____ Co- Insurance: _____ Deductible: _____

Contact: _____ Deductible Met: Y N (\$ _____ met)

Policy Effective Date: _____ Out of Pocket Max: _____

Out of Pocket Met: Y N (\$ _____ met)

Visits Per Year: _____

Additional Information/Restrictions: _____

Case Mgr/Adjuster: _____ Case Nurse: _____

Phone: _____ x _____ Phone: _____ x _____

Fax: _____ Fax: _____

X _____

Patient Signature

Date

We Look Forward to Seeing You Soon!