The Physical Therapy Experience

Patient Information

Name:__________________________ Date of Birth:______________Sex:__________

Address:______________________City:________________ State/Zip:__________

Home Phone:____________________ Work Phone:__________________________

Cell Phone:______________________ Social Security: ______________________

E-Mail Address:____

Employer's Name:____

Employer's Address:____

****Referring Doctor**:____

Whom may we thank for this referral?____________________________________

Insurance Information (PLEASE FILL OUT **A** OR **B**)

A. Private Insurance

Insurance Name:______________________ ID Number:______________________

Policy Holder's Name:___________________ Policy Holder's Date of Birth:___________

Secondary Insurance (If applicable):________________ ID Number:________________

B. Worker's Compensation/No-Fault (PLEASE CIRCLE ONE)

Insurance Name:____

Insurance Address:____

Date of Accident:______________________Policy Number:____________________

Claim Number:________________________Case Manager: ____________________

Carrier Case Number:___________________ (if have one)

Phone Number & EXT:___________________Fax Number:_____________________

*I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORAMTION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE:__________________________ DATE:_______________

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PT EXPERIENCE, PLLC. FOR PROFESSIONAL SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE:__________________________ DATE:_______________

OUR GREATEST APPRECIATION IS YOUR REFERRAL TO OTHERS. THANK YOU!