ProActive Physical Therapy, LLC

"Be ProActive, Not ReActive"

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ _____

Home Mobile Emergency Email Address

(2) Patient **Sex: M F** **Birthdate:** _____/_____/_____

S.S # XXX/XX/_____ **Legal Photo ID #** _____

(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: _____

Date condition began?			Date:____/____/____
Is it related to an auto accident?	No	Yes	Date of accident ____/____/____
Is it a non-work related accident?	No	Yes	Date of accident ____/____/____
Did this condition result in surgery?	No	Yes	If Yes, date of surgery ____/____/____
Have You Had PT for this Condition?	No	Yes	If Yes, Where?_____
Have you had chiropractic services for this condition?	No	Yes	If Yes, where?_____ If Yes, when? _____

(4) Patient's Doctor: Please list the Doctor who referred you to therapy or your Primary Care doctor

_____ **Office Phone:** (____) _____-_____

Dr's Name: Last First Initial MD, DO, DDS, Other

_____

Address: Street City,State Zip Code

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(5) If Filing Insurance : Check A or B

A. ____ **Patient is the insured** (Do not need to complete the rest of #5 or any of #6)

B. ____ **Insured is** ___**Spouse** ____**Parent** (Complete all of #5 and all of #6)

Name: Last First Initial Sr./Jr.

Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____ (___) ____-____
Home Mobile Work Emergency

(6) Insured Person:

Complete if not the patient

Date of Birth: ____/____/____ **S.S. #** XXX/XX_____

Legal ID # _____ **Insured's Sex: M F**

___ **Employed** ___ **Unemployed** ___ **Retired**

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____ **Employer Phone # ( ) _____- _____**

Address: _____ _____
Street City State Zip Code

Name of Employer Contact: _____ Contact's Phone # ( ) _____- _____

(8) Payer Information:

Primary Insurance Company:

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph #_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Secondary Insurance Company: (If YES, please complete) **Insured is: _____Patient _____Spouse _____Parent**

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph#_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # ( ) _____- _____**

Address: _____ _____
Street City State Zip Code

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(9) Medications : (This includes prescriptions, over the counter drugs, herbal and nutritional supplements)

Medication/Drug or Supplement Name	Prescription		Dosage	Frequency Per Day				Route of Administration				
	Yes	No		1	2	3	4	Oral	IV	Injection	Patch	Other

(10) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials

I authorize that the payment of my insurance benefits be made directly to ProActive Physical Therapy, LLC for all services delivered; if I am paid directly I will promptly pay ProActive Physical Therapy, LLC all monies paid to me

_____ **Guarantee of Payment**

Initials

I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date

_____ **Certification of Information**

Initials

I certify that the information I have provided ProActive Physical Therapy, LLC for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful

(11) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**