

PATIENT INFORMATION

PATIENT NAME:		ADDRESS:			
CITY:		ST:	ZIP:		
HOME PHONE:		CELL PHONE:			
DOB:	SS #:	MARITAL STATUS:		S	M W D
EMPLOYER:		PHONE #			
INSURED'S NAME:		ADDRESS:			
CITY:		ST:	ZIP:		
HOME PHONE:		CELL PHONE:			
RELATIONSHIP TO PATIENT:		SELF	SPOUSE	GUARDIAN	
EMPLOYER:		PHONE #:			
PRIMARY:	GRP #:	ID #:			
SECONDARY:	GRP #:	ID #:			
REFERRING DR:		PRIMARY DR:			
LAST DR APPT:		NEXT DR APPT:			
Do you have a secondary (supplemental) insurance?				YES	<input type="checkbox"/> NO <input type="checkbox"/>
Is your injury work, accident or auto related?				YES	<input type="checkbox"/> NO <input type="checkbox"/>
Are you receiving any health related services other than outpatient physical therapy? (Home health nurse or aide)				YES	<input type="checkbox"/> NO <input type="checkbox"/>
Have you received any out patient physical therapy during the current calendar year? If yes, with what clinic. _____				YES	<input type="checkbox"/> NO <input type="checkbox"/>
RELEASE OF INFORMATION: Allen Therapies, Inc. may release any medical information necessary to process my insurance claim.				YES	<input type="checkbox"/> NO <input type="checkbox"/>
ASSIGNMENT OF INSURANCE BENEFITS: I authorize my insurance company to make payment directly to Allen Therapies, Inc. for services rendered to me or my insured dependent.				YES	<input type="checkbox"/> NO <input type="checkbox"/>
MEDICARE ASSIGNMENT: Allen Therapies, Inc. agrees to accept the Medicare allowable amount as the full charge. I am responsible for the deductible, co-insurance and non-covered services. My signature below represents authorization to bill Medicare for services rendered to me.				YES	<input type="checkbox"/> NO <input type="checkbox"/>
CONSENT TO TREATMENT: I hereby give written consent to evaluation and treatment by a licensed physical therapist employed by Allen Therapies, Inc.				YES	<input type="checkbox"/> NO <input type="checkbox"/>
I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sheets and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or the above information.				YES	<input type="checkbox"/> NO <input type="checkbox"/>

ALLEN THERAPIES, INC. WILL NOT ASSUME FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED THAT MAY REQUIRE PRIOR APPROVAL FROM PATIENT'S PRIMARY CARE PHYSICIAN.

SIGNATURE OF PATIENT OR GUARDIAN

DATE