

PATIENT INFORMATION

ACCOUNT NUMBER:

PATIENT NAME:		MAILING ADDRESS:				
CITY:	ST:	ZIP:				
HOME PHONE:		CELL PHONE:				
DL #	ST:	EMAIL ADDRESS:				
DOB: / /	SS #:	MARITAL STATUS:	S	M	W	D
EMPLOYER:		PHONE #				
INSURED'S RELATIONSHIP TO PATIENT:		SELF	SPOUSE	PARENT / GUARDIAN		
HOW DID YOU HEAR OF US?		DOCTOR	FRIEND	WEBSITE	NEWSPAPER	PHONE BOOK
OTHER (PLEASE STATE):						

INSURANCE AND DOCTOR INFORMATION

PRIMARY INS:	GRP #:	ID #:
SECONDARY INS:	GRP #:	ID #:
REFERRING DR:	PRIMARY DR:	
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 (are you seeking an attorney)?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Are you receiving any health related services other than outpatient physical therapy? (Home health agency 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"/>
I understand and agree that regardless of my insurance status, <i>I am ultimately responsible for the balance of my account for any professional services rendered.</i> 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
(Under 18 yrs of age, signature of Parent / Legal Guardian)

DATE