



New Patient Intake Form--Health Insurance

Today's date _____

Patient's Full Name _____

Patient's DOB _____

Patient's SS# _____

Home Address _____ City _____ St. _____
Zip _____

Home Phone# _____ cell phone# _____

Referring Physician _____ Diagnosis _____

Date of Injury _____

Reason for visit

Auto Accident _____ Worker's Comp _____

Slip/Fall/PI _____ Other _____

Attorney _____ Phone _____

Place of Employment _____

Job Title _____

Insurance Co. Name _____

ID# _____

Subscriber's Name _____

Telephone # _____

Subscriber's DOB _____

Relationship to patient _____

Has the patient received any previous physical therapy treatment for this injury?

yes _____ no _____

If yes - When _____

Where _____

Health Insurance Benefits

co-pay_____

co-insurance_____

deductible_____

For Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to Maximum Rehab for any services furnished to me by that facility or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. I understand that the services provided to me by Maximum Rehab Physical Therapy are my financial responsibility whether or not paid by insurance.

Signature of Patient

_____ date_____

For all other Patients

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers to my attorney or a physician's office. I hereby authorize direct payment of medical benefits to which I am entitled to Maximum Rehab. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that the services provided to me or my legal dependent by Maximum Rehab Physical Therapy are my financial responsibility whether or not paid by insurance.

Signature of Patient or Responsible

Party_____ date_____