Eval Date: _____
P.T. _____

ELEVATION PHYSICAL THERAPY

Patient Information Form for Private Pay or Insurance

Date of Injury/Sx: _____ Injury/Diagnosis: _____

Referral Source: _____

How did you hear of us? Bonza / Advertising / Event / Friend/Former Pt / Ins / MD / Online / Team/Club

Other/Details: _____

Patient's Name: _____ Parent/Guardian: _____

SSN: _____ DOB: ____/____/____

Address: _____ Phone (H): _____

City/State: _____ Zip: _____ Phone (C): _____

Emerg Contact: _____ Phone: _____

Patient Email: _____

Private Pay

Rate of Evaluation: _____ Rate of Treatment: _____ Injury Screen _____

Primary Insurance

Date Verified: _____

PPO POS HMO

Subscriber Name: _____ DOB: _____

Insurance Co: _____ Eff. Date: _____

Subscriber ID: _____ Group #: _____

Claims Address: _____

Phone #: _____ Other #s: _____

Contact Person: _____ Ref. #: _____

Is the Patient part of a Medical Group? **Y N** Group Name: _____

Rx Req'd? Yes No Auth/PreCert Req'd? Yes No Auth Request #: _____

Deductible Amt: _____ Amt Met: _____ **You Owe:** _____

Co-Pay/Co-Ins: _____ **Co-Insurance Breaksdown to:** _____

Visit Max: _____ /Used: _____ Calendar Consecutive Days Benefit Yr: _____

Combined? PT OT Chiro Speech Respiratory

Notes: Out Of Pocket Max: _____ /Amt Met: _____

Policy & Charge Acknowledgement

I understand that my deductible must be satisfied before any expense will be paid by my insurance plan. Once my deductible is met my insurance will begin to cover a portion of the claim. I am responsible for paying my deductible & co-insurance/co-payment.

I acknowledge & understand the information listed is only a QUOTE of benefits and not a gurantee of payment by the insurance company. I understand that I am responsible for charges not covered by my insurance & for the accuracy of the information stated above.

I consent ELEVATION Physical Therapy & staff to begin Physical Therapy treatment. I hereby authorize payment directly to ELEVATION Physical Therapy of all benefits otherwise payable to me for services rendered by ELEVATION Physical Therapy but not to exceed the reasonable & customary charges for these services.

ELEVATION Physical Therapy reserves the right to charge for appointments cancelled without 24 hours advance notice.

Signature: _____ Date: _____