

Patient Information Form

Date of Call/Registration: Past Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Account Number:		
Patient Information verified DL/photo i.d.: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Last Name/Suffix		First Name	Middle Initial	
Address:		City:	State:	
Zip Code:	Home Phone	Other Phone (Cell)	Email Address	
Date of Birth	SSN	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	
Employer Information				
Employer Name:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student		
Address:		City:	State:	
Zip Code:	Work Phone Number	Patient Occupation		
Emergency Contact Information				
Contact Name:		Phone #	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other	
Physician Information				
Name of Referring Physician:		Telephone #:	RX Date: _____ aa Eval/Treat: <input type="checkbox"/> # of visits: _____	
Additional Questions				
Date of Injury Onset Date	Auto Related: <input type="checkbox"/> Yes-State? _____ <input type="checkbox"/> No Adjuster name: _____ Phone #: _____	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis/Body Part
Post Surgical: <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown		Surgery Description: _____		
Surgery Date (if applicable): _____				
Have you any prior Therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No (PT/OT/SP or Chiropractic)		How did you hear about us?		
MEDICARE ONLY- Additional Questions				
If Medicare, are you currently receiving Home Health Service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Agency ? _____				
If Yes, what type of Home Health Services are you receiving? _____ Last Date of Service _____				
Are you currently residing in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Facility ? _____				
If Yes, are you on/in the "Medicare Unit"? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Medicare, have you received PT, OT or Speech services since the first of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<ul style="list-style-type: none"> • If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? <input type="checkbox"/> Yes <input type="checkbox"/> No • Are you aware of any partial amount used since the first of the year? \$ _____. • If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare. 				
Appointment Date:		Time:	Therapist:	
Intake Completed By: _____ Date: _____		Patient, Please initial here if the above information is complete and correct _____ Date: _____		

Patient Name:

Account Number:

Insurance Information			
Only complete the following if the Primary or Secondary policy holder is not the patient.			
		Primary <input type="checkbox"/>	Secondary <input type="checkbox"/>
Last Name:	First Name:	Middle Initial	SSN
		DOB	
Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name:		Employer Phone #:	
Primary Insurance Section		Secondary Insurance Section	
Payor/Plan		Payor/Plan	
Code:		Code:	
Policy/ID #:	Group #:	Policy/ID #:	Group #:
Insurance Phone #:		Insurance Phone #:	
<u>All Information Below "FOR OFFICE USE ONLY"</u>		<u>All Information Below "FOR OFFICE USE ONLY"</u>	
Verification		Verification	
AT: _____ FSC: _____			
Date:	Spoke with:	Date:	Spoke with:
Verify Plan: _____ Effective Date: _____		Verify Plan: _____ Effective Date: _____	
Is this a Federally Funded Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a Federally Funded Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does patient have both PT and/or OT coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does patient have both PT and/or OT coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Informed Payor this is outpatient therapy performed in an office setting. <input type="checkbox"/>		Informed Payor this is outpatient therapy performed in an office setting <input type="checkbox"/>	
Visit Limitation:	Coverage:	Visit Limitation:	Coverage:
Limitations on Modalities or Units?		Limitations on Modalities or Units?	
Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___		Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___	
Other _____ / _____ Other _____ / _____		Other _____ / _____ Other _____ / _____	
Comments/Special Instructions:		Comments/Special Instructions:	
Deductible: \$	Out Of Pocket: \$	Deductible: \$	Out Of Pocket: \$
Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Met: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$		Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$	
Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>		Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>	
Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert		Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert	
If any of the above is required, verify that it is on file? <input type="checkbox"/>		If any of the above is required, verify that it is on file? <input type="checkbox"/>	
Auth #: _____	# of Auth Visits: _____	Auth #: _____	# of Auth Visits: _____
Auth Start Date: _____	Auth Exp Date: _____	Auth Start Date: _____	Auth Exp Date: _____
Claims Address:		Claims Address:	

Verification (Workers Compensation)

Is this a State Funded <input type="checkbox"/> or Self Insured plan <input type="checkbox"/> (call employer)	Plan Name: _____
Claim Number: _____	Dx Codes on file: _____
<input type="checkbox"/> Allowed <input type="checkbox"/> In Process <input type="checkbox"/> Pending <input type="checkbox"/> Hearing <input type="checkbox"/> Other	
Adjuster Name: _____	Phone: _____ Fax: _____
Nurse/Case Manager Name: _____	Phone: _____ Fax: _____
Additional Notes:	

Verified By: _____

Date: _____