PHYSICAL THERAPY

PATIENT INFORMATION **PRIVATE INSURANCE** **DATE:_____**

(Please Print, Black Ink Only)

Patient Name:_____ Home Phone: _____

Address:_____ Cell/Pager#:_____

City & State: _____ Zip:_____ e-mail: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W Soc. Sec#: _____

Responsible Party:_____ **Relationship to patient**:_____

Employer: _____Bus. Phone: _____

Address: _____City & State: _____ Zip: _____

Occupation: _____ Student Status: Full Time or Part Time

Emergency Contact: _____ **Telephone**:_____

Physician's Name: _____UPIN#:_____NPI #:_____

Address: _____City & State: _____Zip: _____

Telephone: _____ Fax:_____

Dx:_____ Surgery? Yes/No Date of Sx: _____

Primary Ins.:_____Telephone: _____

Address: _____City & State: _____Zip:_____

Insured's Name: _____ Date of Birth: _____

ID# / SS: _____ **Group**/Policy#: _____

Deductible $_____ Met? Yes/No – How much has been met? $ _____ P.T. Paid at _____%

Co-Pay Per visit $_____ Policy Limits (#Visits/Max $ Per day/Exclusions): _____

Out of Pocket Max $_____ Met? Y/N – How much has been met? $ _____ _____

Effec. Date: _____ On Account to keep up with co-insurance balance_____

Requires Pre-Auth? Yes/No _____

Auth #: _____ Is CPRx a contract provider? YES/NO Benefits given by_____

Who referred patient / How did patient hear of our facility?_____

Therapist _____ Appt. Date & Time:_____ Revised July 2008

Patient's Signature_____ CPRx Officer Signature_____

☐ Ins Coverage Info ☐ Billing Face Sheet ☐ Staffing Sheet ☐ Stamp Charts ☐ Doc's List