

Patient Information

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY NUMBER: _____ **AGE:** _____

SEX: M F **MARITAL STATUS:** S M W D
Email Address: _____

ADDRESS: _____ **HOME PHONE:** ()

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ **DAYTIME PHONE:** ()

HOW DID YOU HEAR ABOUT US? _____

REFERRING PHYSICIAN: _____ **PHONE:** ()

FAMILY PHYSICIAN: _____ **PHONE:** ()

PATIENT'S EMPLOYER: _____ **WORK PHONE:** ()

ADDRESS: _____

CITY/STATE : _____ **ZIP CODE:** _____

POSITION: _____ **YEARS ON JOB:** _____

IS INSURANCE UNDER ANOTHER PERSON'S NAME? (SPOUSE/PARENT/OTHER) _____

NAME OF INSURED: _____ **DATE OF BIRTH:** _____ **RELATIONSHIP:** _____

INSURED'S EMPLOYER: _____ **WORK PHONE:** ()

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

INSURANCE BENEFITS: _____ **VISITS:** _____ **PER CONDITION/CALENDAR YEAR**

\$ _____ **DEDUCTIBLE** _____ **\$** _____ **COPAY**

OTHER INFORMATION: _____

COPAYMENT IS TO BE PAID WEEKLY.

Due to constantly changing insurance regulations, benefits, and deductibles, we are only able to approximate your insurance benefits. If your insurance pays more than expected, you will be credited the difference. If your insurance company pays less than expected, you will be charged for the difference. Final responsibility for payment rests with the person responsible for your account.

Upon admission to our facility, it is very important that you, the patient, inform us, the provider, regarding the circumstances surrounding your injury. In certain instances, an insurance company may recoup payment for information withheld from the providers or the patients.

Have you given the office staff a copy of your insurance cards and prescription for physical therapy? _____ yes _____ no (If no, please explain): _____

If applicable, have you given the office staff any litigation details and/or attorney information, necessary to process your claim? _____ yes _____ no (If no, please explain): _____
Attorney Name/Address/Phone: _____
Court/Case Number: _____

The insurance benefit information listed on page one is the expected eligible coverage for your insurance contract and we will process your insurance claim. You must realize that your insurance coverage is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We are legally required to charge for deductibles and copays that apply to your contract. These charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If necessary, please contact us promptly for assistance in the management of your account.

- I hereby authorize direct payment of benefits to David Gilboe and Associates, Inc. I understand that I am financially responsible to David Gilboe and Associates, Inc. for charges not covered by insurance.
- I understand that I am obligated to pay all copayments at the time agreed upon by David Gilboe and Associates, Inc., and myself.
- I authorize any holder of medical or other information about me to release such information as necessary to process these claims or related medical claims.
- I authorize David Gilboe and Assoc., Inc, to release any information about me necessary to process claims related to my medical condition to the Social Security Administration.
- I permit a copy of this authorization to be used in place of the original.

Pursuant to Title VI, Section 504 of the Rehabilitation Act of 1973, it is the policy of David Gilboe and Associates, Inc., to employ, admit and treat all persons without regard to race, color, national origin, handicap, contagious disease or age.

I have received and read this agreement and declare that the information is true to the best of my knowledge and belief. I understand and agree to all of the terms.

Patient Signature (if minor, parent or guardian) _____ Date _____

Witness Signature (David Gilboe and Associates, Inc.) _____ Date _____