STARACE TOTAL BALANCE
PHYSICAL THERAPY P.A.

Patient Information

Please Print

Claim Type: (check one) ☐ Workers' Compensation ☐ Health Insurance ☐ Self-Pay ☐ Personal Injury/Attorney

PATIENT DEMOGRAPHICS

First Name | Middle Name | Last Name | Suffix | Social Security Number | Date of Birth | ☐ Male ☐ Female

Mailing Address | Apt. # | City | State | Zip

Home Phone Number | Cell Phone Number | Email Address | Language | ☐ Single ☐ Married

Have you been treated at Starace Total Balance PT before? ☐ Yes ☐ No

How did you hear about us? ☐ Radio ☐ TV ☐ Friend ☐ Referral ☐ Phone Book ☐ Internet ☐ Sign ☐ Other

EMERGENCY CONTACT: Name | Relationship | Phone Number | Address

RESPONSIBLE PARTY: Name | Social Security Number | Address

INJURY DETAILS

Type of Injury | Date of Injury

EMPLOYMENT INFORMATION

Employer Name | Occupation | Employment Status

Employment Contact Name | Phone Number | Address

Has a claim been filed to the workers' compensation carrier? ☐ Yes ☐ No

MEDICAL INSURANCE INFORMATION (Please present your insurance card and ID with this form)

PRIMARY INSURANCE

Insurance Company Name | Policy Number | Group Number | Are you the policyholder? ☐ Yes ☐ No*

*COMPLETE THIS BOX IF YOU ARE NOT THE POLICY HOLDER FOR YOUR PRIMARY INSURANCE

Policy Holder's Name | Date of Birth | Social Security Number | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder's Address | Policy Holder's Employer

SECONDARY INSURANCE

Insurance Company Name | Policy Number | Group Number | Are you the policyholder? ☐ Yes ☐ No*

*COMPLETE THIS BOX IF YOU ARE NOT THE POLICY HOLDER FOR YOUR SECONDARY INSURANCE

Policy Holder's Name | Date of Birth | Social Security Number | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder's Address | Policy Holder's Employer

Do you have Medicare? ☐ Yes ☐ No (If yes, please give a copy of your card to the front desk.)

AUTHORIZATION

By my signature below, I hereby authorize the release of medical information needed to process my claim through my insurance company. I authorize my insurance benefits to be paid directly to Starace Total Balance Physical Therapy P.A. that I am financially responsible for any amounts not covered and/or paid by them. It is the policy of this office to collect charges for services as they are rendered, unless prior arrangements are made and credit is established. Insurance patients are responsible for paying their co-payments and deductible at the time services are rendered.

I hereby authorize such treatment as is necessary and to perform medical treatment on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above authorization for treatment, the reason the above named treatment is considered necessary the advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained to me. I also certify that no guarantee or assurance had been made as to the results that may be obtained.

X

Patient or Responsible Party's Signature | Date