

PLEASE PRINT

PATIENT INFORMATION

Please check claim type:

Workers Compensation Health Insurance Self Pay Personal Injury/Attorney

Patient Information:

Full Name: _____ () male () female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (W): _____ (C): _____

Marital Status: _____ SS#: _____ Date of birth: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Employer: _____ **Occupation:** _____

Employer's Address: _____

Contact person: _____ Phone: _____

Has a claim been filed to the workers compensation carrier? () yes () no

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy holder's name: _____ Date of birth: _____

What is your relationship to policyholder? () self () spouse () child () other

Secondary Insurance: _____ **Policy#:** _____

Type of Injury: _____ Date of Injury: _____

DO YOU HAVE MEDICARE? () YES () NO If yes, please give copy of card to front desk.

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 Progressive Therapy Services and agree 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.

Signed: _____ Date: _____

Responsible party signature (if different from above): _____