DOP_____ **DOS**_____

WELCOME TO NORTHWOOD PHYSICAL THERAPY

(Tayese LLC)

PATIENT INFORMATION

Date:_____

Patient:_____

Sex M F Age: ____

DOB: _____ SSN: _____

Address:_____

_____

City State Zip + 4

Phone: _____ Cell: _____

Single married widowed separated divorced

Occupation:_____
Employer:_____
Employer address:_____
Employer phone:_____

Spouses Name:_____
DOB:_____ SSN:_____
Occupation:_____
Spouse's Employer:_____

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

How did you hear about our facility? _____
._____

E mail address
_____

Primary Physician's Name: (PCP)

_____

***NPI** _____

Referring Physician:

_____

***NPI** _____

Address: _____

_____

City State Zip

Phone: _____

Fax: _____

INSURANCE

Subscriber's Name: _____

Birth date:_____ SSN:_____

Relationship to Patient: ____(child ?) _____(?spouse)

Insurance _____

ID# _____

Group # _____
Is patient covered by additional insurance? Yes No
Secondary Insurance Co: _____
ID # _____

WORKMAN COMPENSATION: Yes No
Insurance Company Name: _____
Claim Number: _____
Phone Number: _____

AUTO ACCIDENT: Yes No
Insurance Company Name: _____
Claim Number: _____
Representative: _____
Phone Number: _____
If present condition due to accident, is an attorney involved?
Yes No

You are responsible for payment of any co-payment at the time of service, including any deductible / coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. <u>You are duly informed in advance of possible non coverage of some items despite our contract. You are responsible for any amount not covered by your insurer. Once we inform you via ABN of possibility of insurance carrier denial of all / any part of your claim, or you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. Contractual cap does not extend to the ABN items.</u>

ASSIGNMENT OF INSURANCE BENEFITS

I the undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document, authorizes Northwood Physical Therapy to submit claims for benefits, for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents. And that I will be bound by this signature as though the undersigned had personally signed the particular claim.

*_____ _____
(Authorized signature of subscriber) Date

*** If under 18 years of age parental consent is required.**