JOHNSTON PHYSICAL THERAPY & SPORTS MEDICINE

Patient Information

Patient Name:_____ Male/Female(circle one) Date: _____

Address:_____ Phone(home):_____

City/State:_____ ZIP:_____ 2nd Phone(work/cell):_____

SS #:_____ Date of Birth:_____

Referring Physician: _____ E-Mail Address:_____

Primary Care Physician(if different):_____ Employer:_____

Treatment Area:_____ Position:_____

Injury Date:_____ ☐ Work Comp ☐ Auto Accident ☐ Sports Injury ☐ Other:_____

Emergency Contact Information

Name:_____ Relationship to Patient:_____

Address:_____ Phone:_____

City/State/ZIP:_____ 2nd Phone:_____

Insurance Information/Employers W/C Carrier

Insurance Company:_____ Contact Name:_____

Member Name:_____ Policy/Claim #:_____

Relationship to Patient:_____ Date of Birth:_____ Group #:_____

Address/Contact:_____

Secondary Insurance(if applicable)

Insurance Company:_____ Contact Name:_____

Member Name:_____ Policy #:_____

Relationship to Patient:_____ Date of Birth:_____ Group #:_____

Other/Phone:_____

VERIFICATION (OFFICE USE ONLY)

Contact Name:_____	Number Called:_____	Date:_____
Effective Date: _____	Physical Therapy Benefits: (Y/N)	Deductible:_____
Verification/Authorization Required?: (Y/N)	Claim / Authorization #:_____	Amount Met:_____
Specific Referral Required?: (Y/N)	Visit Limitations:_____	O.O.P. Max:_____
Verified by:_____	Co-Payment:_____	Amount Met:_____

1. I authorize the release of any medical information necessary to process this claim and to other medical practitioners directly involved with my care.
2. I authorize payment of medical benefits/Government Benefits to the Physical Therapy provider for services described.
3. If insurance company or other 3rd party payor do not make full payment on this claim, I will be responsible for charges accrued for services provided.
4. I have received Johnston Physical Therapy & Sports Medicine's Notice of Privacy Practices.
5. I consent to examination and/or treatment under the supervision of my attending Therapist.

_____ _____

Patient (or Authorized Person's) Signature **Date**

Would you like to receive appointment reminders? ☐Email ☐Text: Cell Provider_____

*****In order to receive text reminders a cellular carrier must be provided