JOHNSTON PHYSICAL THERAPY
AND SPORTS MEDICINE

Patient Information

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

Address:_____ Date of Birth:_____

City/State:_____ ZIP:_____ Phone(home):_____

SS #:_____ 2nd Phone(work/cell):_____

Referring Physician: _____ e-mail address:_____

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

Treatment Area:_____ Position:_____

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

Emergency Contact Information

Name:_____ Relationship to Patient:_____

Address:_____ Phone:_____

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

Insurance Information

Insurance Company:_____ Contact Name:_____

Member Name:_____ Policy #:_____

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

Other/Phone:_____

Secondary Insurance(if applicable)

Insurance Company:_____ Contact Name:_____

Member Name:_____ Policy #:_____

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

Other/Phone:_____

Employers W/C Carrier (work injury only) or **Auto Insurance Carrier** (MVA only)

Company Name: _____ Phone #:_____

Address:_____

Claim #:_____ Contact Person:_____

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 by my attending Therapist.

_____ _____

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