INTERNET FORM

Patient Information Form

Date of Call/Registration: **Past Patient ☐Yes ☐ No**	**Patient Account Number:**

Patient Information verified DL/photo i.d:. ☐ Yes ☐ No

Last Name/Suffix		First Name		Middle Initial
Address:	Apt/Bldg:	City	State:	Zip Code:
Home Phone Contact Method: Ph ☐ E-m☐ Mob☐ Txt☐		Mobile Phone Text Enabled ☐		Email Address No Appointment Reminders ☐
Date of Birth	SSN	Sex: ☐ M ☐ F	Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown	

Employer Information

Employer Name:	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student		
Address:	City	State:	Zip Code:
Work Phone Number	Patient Occupation		

Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Physician Information

Name of Referring Physician:	Telephone #:	RX Date:_____ Eval/Treat: ☐ # of visits:_____

Additional Questions

Date of Injury Onset Date:	Auto Related: ☐ Yes-State? _____ ☐ No **Adjuster name: _____** **Phone #:_____**	Work Related: ☐ Yes ☐ No	Accident Related: ☐ Yes ☐ No	Diagnosis/Body Part:

Attorney Involved: ☐ Yes ☐ No Attorney Name:_____	Attorney Phone#: _____ Attorney Fax #: _____
Post Surgical: ☐Yes / ☐No /☐Unknown Surgery Date (if applicable): _____	Surgery Description: _____
Have you any prior Therapy this year? ☐Yes☐ No (PT/OT/SP or Chiropractic)	How did you hear about us?

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Service? ☐Yes ☐ No If yes, Name of Agency ? _____
If Yes, what type of Home Health Services are you receiving? _____
Last Date of Service_____

If Medicare, have you received PT, OT or Speech services since the first of the year? ☐ Yes ☐ No

- If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No
- Are you aware of any partial amount used since the first of the year? $_____.
- If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Appointment Date:	Time:	Therapist:
Intake Completed By: _____ Date:_____	**Patient, Please initial here if the above information is complete and correct _____Date:_____**	

Patient Name:		**Account Number:**		
Insurance Information				
Only complete the following if the Primary or Secondary policy holder is not the patient. **Primary** ☐ **Secondary** ☐				
Last Name:	First Name:	Middle Initial	SSN	DOB
Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other		Gender: ☐ Male ☐ Female		
Employer Name:		Employer Phone #:		
Primary Insurance Section		**Secondary Insurance Section** **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Child ☐ Other		
Payor/Plan Code:		Payor/Plan Code:		
Policy/ID #:	Group #:	Policy/ID #:	Group #:	
Insurance Phone #:		Insurance Phone #:		
All Information Below "FOR OFFICE USE ONLY"		***All Information Below "FOR OFFICE USE ONLY"***		
Verification **AT:_____ FSC:_____**		**Verification**		
Date:	Spoke with:	Date:	Spoke with:	
Verify Plan: _____ Effective Date: _____ Is this a Federally Funded Plan? ☐Yes ☐ No		Verify Plan: _____ Effective Date: _____		
Does patient have both PT and/or OT coverage? ☐Yes ☐ No		Does patient have both PT and/or OT coverage? ☐Yes ☐ No		
Informed Payor this is outpatient therapy performed in an office setting. ☐		Informed Payor this is outpatient therapy performed in an office setting☐		
Visit Limitation:	Coverage:	Visit Limitation:	Coverage:	
Limitations on Modalities or Units? Home Program/97535___ Anodyne/97026 ___ Aquatic/97113___ Other_____/_____ ____ Other_____/_____ ____		Limitations on Modalities or Units? Home Program/97535___ Anodyne/97026 __ Aquatic/97113___ Other_____/_____ ____ Other_____/_____ ___		
Comments/Special Instructions:		Comments/Special Instructions:		
Deductible: $ Met: ☐Yes ☐No	Out Of Pocket: $ Met: ☐Yes ☐No	Deductible: $ Met: ☐Yes ☐No	Out Of Pocket: $ Met: ☐Yes ☐No	
Does patient have a co-pay? ☐ Yes ☐ No If yes, amount: $ Per Visit? ☐ IE/Re-eval only? ☐		Does patient have a co-pay? ☐ Yes ☐ No If yes, amount: $ Per Visit? ☐ IE/Re-eval only? ☐		
Required for therapy? ☐ Referral ☐ Authorization ☐ Pre-Cert If any of the above is required, verify that it is on file? ☐		Required for therapy? ☐ Referral ☐ Authorization ☐ Pre-Cert If any of the above is required, verify that it is on file? ☐		
Auth #:_____ # of Auth Visits:_____ Auth Start Date:_____ Auth Exp Date: _____		Auth #:_____ # of Auth Visits:_____ Auth Start Date:_____ Auth Exp Date: _____		
Claims Address:		Claims Address:		

Verification (Workers Compensation)

Is this a ☐ State Funded or ☐ Self Insured plan (call employer) Plan Name: _____

Claim Number: _____ Dx Codes on file: _____

☐ Allowed ☐ In Process ☐ Pending ☐ Hearing ☐ Other

Adjuster Name:_____ Adjuster Phone:_____

Adjuster Fax:_____ Adjuster Email:_____

Nurse/Case Manager Name: _____ Nurse/Case Manager Phone:_____

Nurse/Case Manager Fax:_____ Nurse/Case Manager Email:_____

Additional Notes:

Verified By:_____ Date:_____