

# JOHNSTON PHYSICAL THERAPY & SPORTS MEDICINE

## Patient Information

Patient Name: \_\_\_\_\_ Male/Female(circle one) Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone(home): \_\_\_\_\_  
City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_ 2<sup>nd</sup> 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: \_\_\_\_\_ 2<sup>nd</sup> 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)

Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Other: \_\_\_\_\_

## **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 3<sup>rd</sup> 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