Edelman Spine & Orthopaedic Physical Therapy
Patient & Payor Information Form

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Mobile Work

We will text you reminders of your scheduled appointments unless notified otherwise.

(2) Patient

Sex: M F **Birthdate: _____/_____/_____**

Marital Status: S M D W **Emergency Contact: _____ & Phone:** (_____) _____-_____

S.S # _____/_____/_____ **Legal Photo ID # _____**

(3) Condition to be treated in Physical Therapy: _____

Date Condition Began?			Date:____/____/____
Is it Related to an Auto Accident?	No	Yes	Date of Accident ____/____/____
Attorney Name: _____			Phone: _____
Is it a Work Related Accident?	No	Yes	Date of Accident ____/____/____
Is it Non-Work Related Accident?	No	Yes	Date of Accident ____/____/____
Did this Condition Result in Surgery?	No	Yes	If Yes Date of Surgery ____/____/____
Have You Had PT for this Condition?	No	Yes	If Yes Where?_____
Have You Had Chiropractic Services for this Condition?	No	Yes	If Yes Where?_____

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

_____ **Office Phone:** (____) _____-_____
Referring Dr's Name: Last First Initial MD, DO, DDS, Other

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

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(5) If Filing Insurance : Check A or B

A. ____ Patient is the insured (Do not need to complete the rest of #5 or any of #6)

B. ____ Insured is ___Spouse ____Parent (Complete all of #5 and all of #6)

Name: Last First Initial Sr./Jr.

Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____
Home Mobile Work

(6) Insured Person:

Complete if not the patient

Date of Birth: ____/____/____ **S.S. #** _____/_____/_____

TriCare Patients: Sponsor's S.S.# _____/_____/_____

Legal ID # _____ **Insured's Sex: M F**

___ Employed ___ Unemployed ___ Retired

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____ **Employer Phone # ( ) _____- _____**

Name of Employer Contact: _____ **Contact's Phone # ( ) _____- _____**

(8) Payor Information:

Primary Insurance Company:

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph #**_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Secondary Insurance Company: (If YES, please complete) **Insured is: _____Patient _____Spouse _____Parent**

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph#**_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # ( ) _____- _____**

Address: _____ _____
Street City State Zip Code

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(9) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(10) Payment Authorization: ***(Initials required for both statements)***

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer.**

_____ **Certification of Information**

Initials **I certify that the information I have provided Edelman Spine & Orthopaedic Physical Therapy for payment including, but not limited to, Related accidents, illnesses or other insurers is accurate and truthful**

(11) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3