DOP_____ **DOS**_____

WELCOME TO NORTHWOOD PHYSICAL THERAPY

(Tayese LLC)

PATIENT INFORMATION

Date:_____

Patient:_____

Sex ☐ M ☐ F Age: ____

DOB: _____ SSN: _____

Address:_____

_____

City State Zip

Phone: _____ Cell: _____

Sex ☐ M ☐ F Age: _____

☐ Single ☐ married ☐ widowed ☐ separated ☐ divorced

Occupation:_____

Employer:_____

Employer address:_____

Employer phone:_____

Spouses Name:_____

DOB:_____ SSN:_____

Occupation:_____

Spouse's Employer:_____

In case of an emergency, contact

Name: _____

Relationship: _____ Phone: _____

How did you hear about our facility? _____

._____

E mail address

_____

Primary Physician's Name: (PCP).

_____

*****NPI----------**

Referring Physician:

_____

*****NPI----------**

Address: _____

_____

City State Zip

Phone: _____

Fax: _____

INSURANCE

Subscriber Name:_____(?self)

Suscriber d.o.b:_____

Relationship to Patient: _____(?spouse/ child)

Insurance _____

ID# _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Co: _____

ID # _____

WORKMAN COMPENSATION: ☐ **Yes** ☐ **No**

Insurance Company Name: _____

Claim Number: _____

Representative: _____

Phone Number: _____

AUTO ACCICDENT: ☐ **Yes** ☐ **No**

Insurance Company Name: _____

Claim Number: _____

Representative: _____

Phone Number: _____

If present condition due to accident, is an attorney involved?

☐ **Yes** ☐ **No**

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible / coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible from any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

ASSIGNMENT OF INSURANCE BENEFITS

I the undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document, authorizes Northwood Physical Therapy to submit claims for benefits, for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents. And that I will be bound by this signature as though the undersigned had personally signed the particular claim.

* _____ _____

(Authorized signature of subscriber) Date

*** If under 18 years of age parental consent is required.**