



Responsible Party Information: (Last Name, First, Middle Initial) Email address: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_
Name: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_
Address: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_
Person/Relative Not Living With You: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Patient Information: (Last Name, First, Middle Initial) Email address: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_
Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: M / F
Patient's Relationship to responsible Party: Self Spouse Child Other
Social Security No.: \_\_\_/\_\_\_/\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Injury/Accident Related? Yes / No Date of Accident: \_\_\_\_\_ Do you have an Attorney? Yes / No
If Yes, Please give Attorney Name and Phone No.: \_\_\_\_\_
If an accident, is this a Work related injury or Motor Vehicle Accident? (Yes or No) If yes, what is your claim no.? \_\_\_\_\_
Please give the name of the at fault parties Insurance Carrier/Workers Comp. Payer: \_\_\_\_\_

Nearest Relative Name and Address: \_\_\_\_\_
Patient's Employer and Phone No.: \_\_\_\_\_
Primary Care Physician's Name: \_\_\_\_\_ Primary Care Physician Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_
Marital Status: Married Single Divorced Widowed Other
If Married, Spouse's Name and Employer: \_\_\_\_\_

Primary Insurance Information Effective Date: \_\_\_/\_\_\_/\_\_\_
Company Name and Address: \_\_\_\_\_
Member / I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_
Policyholder: \_\_\_\_\_ Policyholder's S.S.#: \_\_\_/\_\_\_/\_\_\_
Patient's Relationship to Policyholder: Self Spouse Child Other \_\_\_\_\_

Secondary Insurance Information Effective Date: \_\_\_/\_\_\_/\_\_\_
Company Name and Address: \_\_\_\_\_
Member / I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_
Policyholder: \_\_\_\_\_ Policyholder's S.S.#: \_\_\_/\_\_\_/\_\_\_
Patient's Relationship to Policyholder: Self Spouse Child Other \_\_\_\_\_

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"MEDICARE PATIENTS"

Are you currently receiving Home Health Care from a Home Health Agency? Yes / No
If yes, Please give name and phone no. of the Home Health Agency: \_\_\_\_\_
Have you received Physical, Occupational, or Speech Therapy from another provider this calendar year? Yes / No
If yes, Please give the name of the clinic or facility: \_\_\_\_\_ How many visits were received? \_\_\_\_\_
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"UNITED HEALTHCARE/DEFINITY PATIENTS"

Have you received Physical, Occupational or Speech Therapy from another provider this calendar year? Yes / No
If yes, Please give the name of the clinic or facility: \_\_\_\_\_ How many visits were received? \_\_\_\_\_
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Authorization and Assignment

I authorize Dutch Physical Therapy, Inc. to release medical information that may be necessary to request claim reimbursement from insurance companies or other payors to whom claims may be submitted.
I also assign claim payments including major medical benefits to be made payable to Dutch Physical Therapy, Inc. I understand that Dutch Physical Therapy, Inc. will refund to me any overpayment upon request, regardless of insurance. This authorization and assignment may be revoked by me at any time by a written notice.

I ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES

Patient Name (Print): \_\_\_\_\_ Patient or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_