

# University City Physical Therapy & *Function*SMART Fitness

## PATIENT INFORMATION

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

EMAIL \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DRIVER LICENSE \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

OCCUPATION/POSITION \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_ ICD-9# \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### INSURANCE INFORMATION

PVT	WC	MEDICARE	AUTO	CASH	HMO	PPO	OTHER
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<b>PRIMARY</b> NAME OF INSURANCE COMPANY _____			
ADDRESS _____	CITY _____	STATE _____	ZIP _____
PHONE _____	CLAIMS ADJUSTER _____	AUTH# _____	
POLICY# _____	GROUP/CLAIM# _____	HOME CARE: YES / NO	
DATE OF INJURY _____	PREVIOUS PT (this injury) YES / NO	# OF VISITS _____	
NETWORK: <b>IN</b> <b>OUT</b>	EFFECTIVE DATE OF COVERAGE _____	DEDUCTIBLE\$ _____	MET\$ _____
COPAY/COINS _____	MAX VISITS OR \$\$ AMT/YR _____	MODALITIES Y/N	MAX PER VISIT _____
AUTHORIZED BY _____	DATES VALID _____	# OF AUTH VISITS _____	
OTHER PLAN LIMITATIONS _____			
<b>SECONDARY</b> NAME OF INSURANCE COMPANY _____			
ADDRESS _____	CITY _____	STATE _____	ZIP _____
PHONE _____	POLICY# _____	GROUP/CLAIM# _____	

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates for service rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE