Date: ___________________________

Patient Name____

Address____

City ____**State** ___________________**Zip**______________________

Home Phone (______**)** ____________________ **Work/Cell Phone/Other (**______**)** ____________________

SSN______________________**DOB**_____________________**E-Mail**__________________________________

(Please note that your e-mail will only be used for TheraMAX communication)

We would like to *Friend* you on Facebook, please provide us with your name, this will only be used for communication purposes: *www.facebook.com/*____

→ Who may we thank for referring you? ____

Referring Physician____ NPI#___________________________

Street Address____ Telephone______________________

City/State/ZIP____ FAX___________________________

Primary Insurance Company _______________________________________ID#_________________________

Policy Holders Name _____________________________________Group#:___________________________

Policy Holders SSN ___________________________Policy Holders DOB_____________________

Insurance Co. Phone#____________________________

Secondary Insurance Company _______________________________________ID#_________________________

Policy Holders Name _____________________________________Group#:___________________________

Policy Holders SSN ___________________________Policy Holders DOB_____________________

Insurance Co. Phone#____________________________

No-Fault Patients Only

Insurance Carrier __________________________________Claim# ________________ Date of Accident___________

Contact: _______________________________________ Telephone__________________ FAX__________________

Policy Holder____Policy#______________________________________

Workers Comp Patients Only

Insurance Carrier __________________________________Claim# ______________ Date of Accident___________

Contact: ____ Telephone_________________ FAX__________________

Employer____ Employer's Telephone_____________________

Address____

I authorize the release of any medical information to my Insurance Carrier to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize the physician(s) to apply for benefits on my behalf for services rendered. I request that payment be made directly to ***Thera*MAX Rehabilitation & Sports Physical Therapy, PLLC**, or its designee. I certify that the information I have reported with regard to my insurance coverage is correct and accurate. I understand that I am financially responsible for the charges incurred for services and supplies received. I authorize the physician(s) to treat me and/or my child.

Signature
(Patient/Guardian):____**Date:**______________________________