TheraMAX
Rehabilitation & Sports Physical Therapy PLLC

Date _____

Name _____ DOB _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home (____) _____ Cell/Other (____) _____ E-Mail _____
(Your email will only be used for TheraMAX communication)

We would like to **FRIEND** you on **FACEBOOK** www.facebook.com/_____

HOW DID YOU FIND US? (PLEASE CHECK ONE)

☐ Web Search/Google
☐ Insurance Company
☐ You were a previous patient
☐ Referred by a patient _____
☐ Other _____
☐ Referred **specifically** by your doctor to TheraMAX

IS YOUR INJURY THE RESULT OF A **CAR** AND/OR **WORK RELATED** ACCIDENT? ☐ YES ☐ NO

REFERRING PHYSICAN

Name _____ NPI# _____

Address _____ Suite/FL _____ Tel (____) _____

City_____ State _____ Zip _____ Fax (____) _____

PRIMARY INSURANCE

Insurance Company _____ ID# _____

Phone (_____) _____ Group# _____

Policy Holder _____ DOB _____

SECONDARY INSURANCE

Insurance Company _____ ID# _____

Phone (_____) _____ Group# _____

Policy Holder _____ DOB _____

NO-FAULT

Insurance Company _____ Claim# _____ Date of Accident _____

Contact _____Tel (____) _____ Ext. _____ Fax (____) _____

Policy Holder _____ Policy # _____

WORKERS COMPENSATION

Insurance Company _____ Claim# _____ Date of Accident _____

Contact _____Tel (____) _____ Ext. _____ Fax (____) _____

Employer _____ Tel (____) _____

Address _____

NO-FAULT / WORKERS COMPENSATION <u>ONLY</u>

Attorney _____ Tel (____) _____ Ext. _____

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 _____ **DATE** _____

(PARENT / GUARDIAN SIGNATURE REQUIRED IF PATIENT IS A MINOR)