

Belmar Physical Therapy, P.C.

Patient Information

Name: _____
Symptoms: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Social Security #: _____ Birthdate: _____

Insurance Information: (leave blank if we have a copy of your insurance card)

Insurance: _____
Insured: _____
Patient's relation to insured: _____ Insured DOB: _____
Policy/claim # _____ Group # _____
Insurance Phone Number: _____

Please call the 1-800 number on the back of your insurance card and obtain the following information:

Deductible: _____ Amount of deductible met: _____ Copay/Coinsurance: _____
Limit on visits?: _____ Pre-Authorization necessary? Yes No

Date of Onset of Pain or Injury: _____

Auto Accident Related? Yes No

Work Related? Yes No

How did you hear about us?

- Physician _____ Walk-in Pharmacy Bag
 Friend _____ Google AdWords Yellow Pages
 Internet Search: Google Yahoo MSN Other: _____

- If we are billing Medicare: Medicare requires that you visit your referring physician every 30 days while receiving physical therapy.
- We will verify your insurance benefits. However, it is the patient's responsibility to know their physical therapy benefits. We cannot be held responsible for errors by the insurance company when verifying benefits.

By signing below:

- I authorize Belmar Physical Therapy, P.C. to release to my insurance company or my doctor any information they may request concerning my present illness or injury.
- I accept responsibility for the cost of services and understand that payment is due at the time of service.
- I hereby consent to such evaluation and treatment which, in the judgment of my physical therapist, is considered necessary while a patient at Belmar Physical Therapy, P.C..

Patient Signature: _____ Date _____

(Signed by parent or guardian if under age 18 or dependent)