Date: _____ Chart#: _____

PATIENT INFORMATION:

Last Name: _____ Maiden Name: _____ First Name: _____ M.I. _____

Address: _____
Street City State Zip County

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Cell Phone #: _____

Email Address: _____

Sex: **M F** (circle one) Marital Status: **S M W D** (circle one) Spouse's Name: _____

Patient's Social Security #: _____ Patient's Date of Birth: _____

Name of Referring Doctor/Primary Care Physician:

_____

PERSON RESPONSIBLE FOR BILL:

Last Name: _____ First Name: _____ M.I. _____

Relationship to Patient: _____ Social Security #: _____ Date of Birth: _____

Address: _____
Street City State Zip County

Home Phone#: ( ) _____ Work Phone#: ( ) _____ Other: ( ) _____

Employer Name: _____

Employer Address: _____
Street City State Zip County

INSURANCE INFORMATION:

1ST Insurance: _____ Policy Holder/Subscriber's Name/Date of Birth: _____

Policy #: _____ Group #: _____

2nd Insurance: _____ Policy Holder/Subscriber's Name/Date of Birth: _____

Policy #: _____ Group#: _____

MEDICARE PATIENTS PLEASE READ AND SIGN

Medicare #: _____ Supplemental Insurance: _____

Policy #: _____ Address: _____

Are you or your spouse currently working? Yes □ No □ If yes, is Medicare Primary? Yes □ No □

I request payment of authorized Medigap benefits be made on my behalf to Onword Therapy for services furnished me by them. I authorize any holder of medical information about me to release to _____
(Medigap Insurer)

Any information needed to determine these benefits on the benefits payable for related services.

Patient's Signature: _____ Date: _____

WORKERS COMPENSATION: _____ Date of Injury: _____

Name of Employer where injury occurred: _____ Claim #: _____

Employer Address: _____ Phone #: _____
Street City State Zip

IF ACCIDENT RELATED

Name of Responsible Ins. Co. _____ Phone #: _____

Address: _____ Date of Injury: _____

Policy Holder Name: _____ Policy #: _____

IMPORTANT INFORMATION…READ CAREFULLY

1. I authorize ONWORD THERAPY to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, insurance companies, and carriers who may be responsible for payment of benefits.
2. I authorize ONWORD THERAPY to release my medical records and billing information to my primary care and referring physician.
3. I authorize my insurance benefits to be paid to ONWORD THERAPY.
4. If a requested insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept the responsibility for collection of your insurance claim or for negotiating settlement on disputed claims. I understand I am responsible for any charges not paid by my insurance.

Signature (Legal Guardian): _____ Date: _____

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COMMUNICATION AUTHORIZATION

May we leave appointment information or return phone call messages with the person who answers the phone? Yes_____ No _____

May we leave appointment information or return phone call messages on your answering machine? Yes_____ No _____ Not applicable _____

CONTACTS:

With whom may we discuss patient's medical information or billing questions?

*NOTE: Please **ONLY** list family members or friends that might call on your behalf. Example: mom, dad, brother, sister, spouse, significant other, etc.*

If you choose not to list anyone, please proceed to the bottom of the page to sign and date.

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____
4. _____ Phone: _____
5. _____ Phone: _____

Print Patient's Name _____

Patient Signature (unless a minor) _____

Date: _____/_____/_____

Please contact us if you want this information updated.