

# Jeff Nicholl Physical Therapy & Sports Rehabilitation, Inc

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Email: \_\_\_\_\_ Who may we thank for referring you to our office? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

<b>Date of Injury or Surgery / Onset of Symptoms:</b> _____				
Do you have Medicare Part A & B?	Yes:		No:	
Is this a work related injury?	Yes:		No:	
Is injury related to an automobile accident?	Yes:		No:	
<b>**Have you received home health services within the last 30 days?</b>	Yes:		No:	
<b>Please Initial:</b> _____				

### Insurance Information

PVT:  WC:  Medicare:  Cash:  HMO:  Auto:

<b>In-Network</b>	<b>Out-Of-Network</b>	<b>Medicare</b>
Insurance Company: _____	Insurance Company: _____	Medicare HICN: _____
ID Number: _____	ID Number: _____	Annual Cap:\$ _____
Deductible:\$ _____	Deductible:\$ _____	Remaining Cap:\$ _____
Met:\$ _____	Met:\$ _____	
Remaining:\$ _____	Remaining:\$ _____	
Out Of Pocket:\$ _____	Out Of Pocket:\$ _____	
Co-Insurance: _____%/_____%	Co-Insurance: _____%/_____%	
Co-Payment: \$ _____	Co-Payment: \$ _____	
Calendar Year Limitations: _____	Calendar Year Limitations: _____	
Quoted By: _____ Date: _____	Quoted By: _____ Date: _____	

I hereby give lifetime authorization for payment or insurance benefits to be made directly to Jeff Nicholl Physical Therapy & Sports Rehab/or its affiliates for services 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 health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time. Any patient who cancels with less than 36 hours notice will be charged \$75.00. Also, any patient who fails to show up to their appointment will be charged \$100.00. This will be due and payable at your next visit. Thank you for your courtesy in this matter. I have read and understand the above policies.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_