

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: _____

Referring Physician: _____ Primary Care Physician: _____

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:	
Date Of Injury:	Attorney Name & Phone:			

Insurance Information

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

In-Network	Out-Of-Network	Medicare
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 24 hours notice will be charged \$35.00. Also, any patient who fails to show up to their appointment will be charged \$50.00. 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: _____