Jeff Nicholl Physical Therapy & Sports Rehabilitation, Inc

Name: ______________________________ 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: ______________________________