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:

Date of Injury or Surgery / Onset of Symptoms: _____				
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:	
Third Party Injury / Ongoing Litigation?	Yes:		No:	

Please Initial: _____

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 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: _____