

ProSport II- RSM

Date & Time of 1st Appt:

Patient Information Profile

Treating Therapist:

<input type="checkbox"/> New Patient <input type="checkbox"/> Re-Start <input type="checkbox"/> New Diagnosis				
Patient #	Title *	Patient Name (Last, First, Middle Initial)		
Address		City/State/Zip		
Home Phone ()	Work Phone/ Cell Phone ()		E-mail Address:	
Social Security #	DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	Financial Class * PVT WC MC
Referring Physician		UPIN	Treating Therapist *	
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA	Primary location ProSport II-RSM	Marital Status *	Student *	Employment Status *
Occupation	Employer			
Address		City/State/Zip		

Emergency Contact (Name)	Home Phone ()	Work Phone ()
Address	City/State/Zip	Relationship to Patient *

Financially Responsible Party if Not Patient

Name (First, Middle Initial, Last)		Relationship to Patient *	
Address		City/State/Zip	
Home Phone ()	Work Phone ()	Email Address	
Social Security #	DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #

Injury Information

Body Part:

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery	Surgical Procedure	
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident	
Describe Accident			
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury		
Name of employer at time of accident	City, State, Zip Code		
Describe Injury			
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Attorney	Phone # ()	

-Office Use Only-

Diagnosis:	ICD-9 Code:
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Insurance Information

Patient DOB:

Primary Insurance						
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship to Patient *	
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage% %	Co-Ins% %	Co-Pay \$ \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year
Deductible Start Amount \$		Deductible Remaining Amount \$				
Benefits Verified By		Date	Spoke to		Phone # ()	

Secondary Insurance						
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship to Patient *	
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage% %	Co-Ins% %	Co-Pay \$ \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year
Deductible Start Amount \$		Deductible Remaining Amount \$				
Benefits Verified By		Date	Spoke to		Phone # ()	

These are your insurance benefits as quoted to us by your insurance carrier. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you the patient agree to pay any balance remaining after your insurance carrier has paid its portion of this bill.

Patient Initials	Front Office	CPM

ASSIGNMENT OF INSURANCE BENEFITS

1. It is customary to pay for professional services when rendered. If you cannot settle your account at the time of each office visit, special arrangements must be made in advance with our Office.
2. Patients who have Health Care Insurance should understand that charges for professional services are charged to the patient and not to the insurance company. Payment for charges incurred is the responsibility of the patient or the parent of patient if a minor.
3. Our office will be happy to bill your insurance carrier for you, however we cannot accept responsibility for collecting from your insurance carrier or for negotiating a settlement of a disputed claim. I hereby authorize ProSport II- RSM to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Patient Signature _____ Date _____