OrthoSport PATIENT INFORMATION SHEET

Physical Therapy Center, Inc.

46615 Michigan Ave. Canton, MI 48188
Phone: (734) 961-9626 Fax: (734) 961-9627

Referral Date:_____ Appt Date:_____ PT:_____

PATIENT NAME:_____

Date of Birth:_____ Age:_____ E-Mail:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone#:_____ Cell#:_____ Work#:_____

Emergency Contact:_____ _____ Phone#:_____

INSURANCE INFORMATION Date of Injury:_____

□ Medicare #:_____ Start of Coverage:_____

□ BCBS □ BCN Contract #:_____ Group #_____ Service Code:_____

Subscriber's name (if not self):_____ Subs. DOB:_____

□ WC □ MVA Claim#:_____ Contact:_____ Phone#:_____

Company/Agency:_____ Phone#:_____

Address:_____

□ Private Ins. □ Secondary Ins.:_____ Ins#:_____

Address:_____ Phone#:_____

Subscriber's name (if not self):_____ Subs. DOB:_____

□ Self Pay □ Co-Pay

Verification Made By:_____ Date:_____ Co-pay:_____%

Deductible:_____ Per Person:_____ Per Family:_____

Out of Pocket:_____ Per Person:_____ Per Family:_____

Number of Visits:_____ Per Calendar Year:_____ Per Diagnosis:_____

Comments:_____

PHYSICIAN:_____ DX:_____ _____ ICD-9:_____

SOC:_____ DX:_____ ICD-9:_____

CONSENT: I hereby authorize the staff at OrthoSport Physical Therapy Center to perform an initial physical therapy evaluation and physical therapy treatment as deemed necessary by my providers.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to ORTHOSPORT Physical Therapy Center, Inc. of the Medical Benefits, if any, otherwise payable to me for the services as described below but do not exceed the reasonable and customary charge for those services. I agree to pay in full any and all charges, including co-payments and deductibles, for provider services not otherwise covered by insurance benefits.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the ORTHOSPORT to release any information required in the course of my examination or treatment.

Patient Signiature:_____ Date:_____