Date: _____ **Patient Name:** _____ **Patient DOB:** _____

Insured Party: (if different from the patient)

Name: _____
First Middle Initial Last
Address: _____
Street City State Zip
Date of Birth: ____/____/____ Gender: Male or Female SSN _____
Month Date Year
Phone#: Home _____ Cell _____ Work _____
Relationship to Patient: _____
Employer: _____

Insurance Information: (Office Use Only) Verification/Authorization Date: _____
Primary Insurance Company: _____ Ins Claim Adj/Verifier: _____
Phone#: _____ Fax#: _____
Policy Effective Date: _____
ID or Claim#: _____ Group#: _____ Group Name: _____
Authorization #: _____ # of Visits Authorized: _____ Authorization Expiration Date: _____
Deductible: Single $_____ Met $_____ Family $_____ Met $_____
OOP: Single $_____ Met $_____ Family $_____ Met $_____
Deductible included in the OOP amount: Yes No DME: _____ Script: Yes No
Patient Percentage: _____ OR Copay: _____ Max $ Amount Allowed: _____
# of Visits Allowed: _____ # of Visits Used: _____
PT Script Required: Yes No
Precertification Required: Yes No ACN Certification: Yes No

CPT Codes Excluded: G0283 97014 97016 97033 97140 97124 97762 97035 97010

Comments: _____
_____

Secondary Insurance Information: (Office Use Only)
Primary Insurance Company: _____ Ins Claim Adj/Verifier: _____
Phone#: _____ Fax#: _____
Insured Name: _____ Date of Birth: _____ Gender: M F
Policy Effective Date: _____
ID or Claim# _____ Group#: _____ Group Name: _____
Deductible: Single $_____ Met $_____ Family $_____ Met $_____
OOP: Single $_____ Met $_____ Family $_____ Met $_____
Deductible included in the OOP amount: Yes No
Patient Percentage: _____ OR Copay: _____ Max $ Amount Allowed: _____
# of Visits Allowed: _____ # of Visits Used: _____
PT Script Required: Yes No

CPT Codes Excluded: G0283 97014 97016 97033 97140 97124 97762 97035 97010

Comments: _____
_____