Outreach Physical & Occupational Therapy & Speech Rehabilitation, PLLC
CLINIC SETTING

Please, either fill out in office, fax, mail or bring in below with prescription from Doctor

MEDICARE Patient Information:
Full Name (as on Insurance ID card)____
Address___________________________________ City____________State____Zip____________
Home Phone #___________________Cell #____________________email:____________________
Social Security #__________________________ Date of Birth______________sex: ☐ M ☐ F
Family/Friend/Emergency Contact Name____
Relationship_______________________Ph #__________________ email____________________

LEGAL PHOTO ID #: i.e.) driver's license or passport #______________________________

Are you currently receiving Home Health Services ☐ yes ☐ no if yes, from who?
_________________________________IE) home attendant or Nurse

How would you like to receive appointment reminders?
☐ Call me at home ☐ call my mobile ☐ text my mobile ☐ E-Mail me

REFERRAL:
How did u hear about us? ____

TYPE OF THERAPY NEEDED, CHECK OFF: ☐ Physical ☐ Occupational
☐Speech ☐ Swallow (Medicare only)

Medical History and Precautions (brief) : ____

PATIENT INSURANCE INFORMATION:

In Network Physical/Occupational: ☐ Medicare

Private Pay: ☐PT ☐ OT ☐ SLP: ($110/Session (up to 60 minutes) $60/session (up to 30 minutes)

Above Primary Ins. Member ID #/policy #_________________

Secondary Ins.: Company Name / Member ID #______________________/______________________

Secondary insurance Co. phone #(____) ________-__________________

Secondary insurance Co. Address____

OPTIONAL CREDIT CARD AUTHORIZATION: I hereby authorize Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC to charge my credit card for services rendered for a period of one year from the date below. It is my responsibility

Name on card________________________ **Signature/ date**_________________________

Credit card type ☐ MasterCard ☐ Visa ☐ American express ☐ Discover

Credit card #_________________________**expiration date/ security code**_____________

Billing zip code_____________

PAYMENT AUTHORIZATION:

Initials______ Assignment of insurance benefits

I authorize that the payment of my insurance benefits be made directly to Outreach PT, OT , ST, PLLC for all services delivered; if I am paid directly I will promptly pay Outreach PT, OT , ST, PLLC all monies paid to me

Initials______ Guarantee of Payment

I understand that all payments designated as "the patients responsibility" such as co-insurance and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date

Initials______ Certification of Information

I certify that the information I have provided Outreach PT, OT and ST, PLLC for payment including , but not limited to , related accidents, illnesses or other insurers is accurate and truthful.

ATTESTATION:

I attest, to the best of my knowledge, the above information is accurate and true

Signature/date:

Patient/legal representatives Signature __________________________Todays date_________

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