Facility: _____

PATIENT INFORMATION

Physio O&P

Mr. Mrs. Miss

Patient Name _____ Date of Birth: _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone #: _____ Email: _____

Cell Phone #: _____ Marital Status: Married Single Divorced Widowed Minor

Are you currently in: □ Nursing Home □ Hospital □ Incarcerated □ Other _____

Employer _____ Employer Phone # _____

Employer Address _____

City _____ State _____ Zip Code _____

Spouse/Parent/Guardian (Circle One) _____

Spouse/Parent/Guardian Home Phone # _____ Work Phone # _____

Nearest Relative/Friend Not Living With You _____ Phone # _____

Emergency Contact _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

How did you hear about us? _____

MEDICAL INFORMATION

Referring Physician _____ Primary Care Physician _____

Nature of Injury _____ Date of Injury _____

Injury Related To: Birth Auto Accident Other Accident Work -- If Work Related, Please Answer the Following:

Employer at Time of Injury _____ Phone # _____

Address _____

City _____ State _____ Zip Code _____

Workers Comp. Insurance Name _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Claim # _____

Adjuster Name _____ Extension # _____

INSURANCE INFORMATION

How do you intend to pay for your portion? Cash Check

Primary Insurance _____ Address _____

City _____ State _____ Zip Code _____ Phone # _____

Policy # _____ Group Name/Number _____

Name of Insured _____ Date of Birth _____

Relation to Patient: Self Spouse Parent Other _____ Insured's Employer _____

Secondary Insurance _____ Address _____

City _____ State _____ Zip Code _____ Phone # _____

Policy # _____ Group Name/Number _____

Name of Insured _____ Date of Birth _____

Relation to Patient: Self Spouse Parent Other _____ Insured's Employer _____

Assignment of Benefits / Authority for Release of Information /HIPAA Acknowledgement:

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Freedom Management Services, Inc., for any covered services furnished to me by this facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician, or I fail to provide within thirty (30) days the information necessary to submit the claim for payment. I also hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Benchmark Medical Inc. and hereby consent to the use and disclosure of my personal health information for the purposes of treatments, payment, and health care operations.

X _____

Beneficiary / Parent / Guardian Date