



**PROLIANCE
SPORTS THERAPY
& REHABILITATION**



PATIENT INFORMATION					
PATIENT'S LAST NAME:		FIRST:	MIDDLE:	BIRTHDATE:	AGE: SEX: <input type="checkbox"/> M <input type="checkbox"/> F
CURRENT ADDRESS:			SOCIAL SECURITY:	HOME PHONE: ()	
CITY:	STATE:	ZIP CODE:	BILLING ADDRESS (if different):		
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER			SPOUSE'S NAME:		
OCCUPATION:			EMPLOYER/SCHOOL NAME:	EMPLOYER PHONE: ()	

REFERRING PHYSICIAN INFORMATION		
DOCTOR'S NAME:	PHONE NUMBER: ()	ADDRESS/CLINIC NAME:

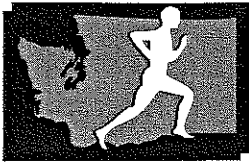
REASON FOR TODAY'S VISIT	
IS THIS INJURY/CONDITION RELATED TO: <input type="checkbox"/> WORK <input type="checkbox"/> CAR <input type="checkbox"/> HOME <input type="checkbox"/> OTHER	DATE OF INJURY OR 1 ST SYMPTOMS:

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
NAME OF POLICY HOLDER:	BIRTH DATE: / /	ADDRESS (if different):	HOME PHONE: ()
NAME OF INSURANCE COMPANY:	POLICY NUMBER/CLAIM NUMBER:		GROUP NUMBER:
CLAIM MANAGER (If Applicable):			CLAIM MANAGER PHONE NUMBER: ()
PATIENT'S RELATIONSHIP TO POLICY HOLDER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			

IF PATIENT IS A MINOR		
NAME OF GUARANTOR:	BIRTH DATE: / /	RELATIONSHIP:

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION			
NAME (Last, First, Middle):	RELATIONSHIP:	HOME PHONE: ()	DAY PHONE: ()

RESPONSIBLE PARTY STATEMENT	
As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and health care institutions as is necessary to my care and treatment.	
_____ SIGNATURE OF PATIENT/GUARDIAN	_____ DATE



**WELCOME TO PROLIANCE SPORTS THERAPY &
REHABILITATION**

Insurance Information: As a courtesy to you, we will bill your insurance company. Please provide us with your insurance card and any additional information we may need. It is not uncommon for your insurance policy to have rehabilitation benefits with visit limits and/or dollar limits. We recommend that you call your insurance company to verify your physical therapy coverage. **It is your responsibility to know your policy benefits and limitations.** Our billing office is available to answer questions you may have regarding our billing procedures. If you have any financial problems, please communicate them as soon as possible so that we may work out a mutually beneficial payment plan.

Payment Option: We accept personal checks, cash, Visa and MasterCard. **Insurance co-payments are due on each visit.** Any portion of your treatments that are not covered by your insurance becomes your responsibility and is due within 30 days.

Worker's Compensation Claims: We will bill your **open** approved workers compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

Supplies: Supplies purchased by the patient are payable at the time of services. We will provide you with a receipt so you may seek reimbursement from your insurance company.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage do not hesitate to ask for our assistance.

Patient Signature

Date