

# ProActive Physical Therapy, LLC

"Be ProActive, Not ReActive"

**All Patients or Patients' Legal Representative, please complete all Sections**

**( 1 ) Patient: (Full Legal Name or as on Insurance Card )**

**Name:** \_\_\_\_\_  
Last First Initial Sr. Jr.

**Address:** \_\_\_\_\_  
Street Apt# City State Zip Code

**Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_  
Home Mobile Emergency Email Address

**( 2 ) Patient**

**Sex:** M F

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**S.S #** XXX/XX/\_\_\_\_

**Legal Photo ID #** \_\_\_\_\_  
( Driver's License, Passport, Other State/Federal Photo ID)

**( 3 ) Condition to be treated in Physical Therapy:** \_\_\_\_\_

Auto Accident? No Yes Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Non-Work Related Accident? No Yes Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery \_\_\_\_/\_\_\_\_/\_\_\_\_

Have You Had PT for this Condition? No Yes If Yes Where? \_\_\_\_\_

Have You Had Chiropractic Services for this Condition? No Yes If Yes Where? \_\_\_\_\_

**( 4 ) Patient's Doctor:** Please list the doctor who referred you to therapy or your Primary Care doctor

\_\_\_\_\_ **Office Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Dr's Name:** Last First Initial MD, DO, DDS, Other

**Address:** \_\_\_\_\_  
Street City, State Zip Code

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## ( 5 ) Auto or Non-Work Accident Claim—

The Claim will be paid by:  Your Personal Car Insurance  Liability Claim (Another Person's Insurance)

Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_ FAX # ( ) \_\_\_\_\_ - \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_  
Street City State Zip Code

### If pursuing litigation:

Name of Law Firm : \_\_\_\_\_ Name of Attorney: \_\_\_\_\_

Address of Law Firm: \_\_\_\_\_  
Street City State Zip Code

Phone # of Law Firm: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax # ( ) \_\_\_\_\_ - \_\_\_\_\_

Sign: A or B

- A) I understand that I and my attorney must agree to the terms of ProActive Physical Therapy, LLC's "Letter of Protection/Lien" in order for a liability claim to be considered as a payment source.

Patient's Signature: \_\_\_\_\_

- B) I understand that if I am using my personal car insurance I must assign payment benefits to ProActive Physical Therapy, LLC and be prepared to pay should I exhaust the medical funds:

Patient's Signature: \_\_\_\_\_

## (6) Medical Insurance Information (please provide a copy of Insurance card and complete this section in the event that your Auto or Non-Work Accident claim is denied)

Ins. Co. Name: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured is  Patient  Spouse  Parent

Sex: M F Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient ID #: \_\_\_\_\_ Group. # \_\_\_\_\_ Policy/Plan #: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Employer Name: \_\_\_\_\_ Employer Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

