ProActive
Physical Therapy, LLC

***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 Work Email Address

(2) Patient **Sex: M F** **Birthdate:** _____/_____/_____

S.S # _____/_____/_____ **Legal Photo ID #** _____
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: _____

Did this Condition Result in Surgery?	No Yes	If Yes Date of Surgery ____/____/____
Did this Condition Result from a Work Injury?	No Yes	If Yes Date of Accident ____/____/____
Have You Had PT Anywhere this Year?	No Yes	If Yes Where?_____
Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you?)	No Yes	If Yes From Who?_____
Do You Live in a Nursing Home?	No Yes	If Yes What Is Its Name? _____
Are You Covered:		
· Under Black Lung Disease?	No Yes	
· End Stage Renal Disease?	No Yes	
· Large Group Insurance?	No Yes	If Yes Name/Group #_____
· Veterans Affairs	No Yes	

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (____) _____-_____

Address: Street City,State Zip Code

(5) Payor Information Primary:

Primary Insurance Company: Medicare

Insured's Name:_____ **Patient ID #** _____ **Group #** _____

Regular Medicare: Yes No **Rail Road Medicare: Yes No**

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(6) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph#_____

Insured is: _____Patient _____Spouse _____Parent

Patient ID #: _____Group. # _____ Policy/Plan #: _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ Employer Phone # ( ) _____- _____

Address: _____ _____
Street City State Zip Code

(7) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

(8) Payment Authorization: *(Initials required for all 3 statements)*

_____ **Assignment of Insurance Benefits**

Initials I authorize that the payment of my insurance benefits be made directly to LPT for any services that are reimbursable by Medicare or my any other insurance company, if I have one.

_____ **Guarantee of Payment**

Initials I understand that all payments designated as 'the patient's responsibility' such as co-insurances 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 the billing statement due date.

_____ **Certification of Information**

Initials I certify that the information I have provided LPT for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(9) Signature/ Date:

_____ _____
Patient or Legal Representative's Signature Today's Date