NEO THERAPY - PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME: _____ SS#:_____ TODAY'S DATE _____

HOME ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK PHONE: _____

DATE OF BIRTH: _____ AGE _____

PLEASE CIRCLE ONE: MALE/ FEMALE SINGLE MARRIED DIVORCED WIDOWED MINOR

SPOUSE'S/ GUARDIAN NAME: _____ SS #: _____ DOB: _____

WORKERS COMP YES/ NO DATE OR INJURY: _____

ARE YOU CURRENTLY WORKING? YES/ NO IF NOT, LAST DAY WORKED_____

RETURN TO WORK DATE _____ TYPE OF JOB _____

CLAIM # _____ INSURANCE COMPANY _____

PRIMARY CARDHOLDER _____GROUP # _____

PRIMARY INSURED SS#_____ DO YOU HAVE SECONDARY COVERAGE? Y / N

SECONDARY INSURANCE CARDHOLDER_____ GROUP/POILCY # _____

EMPLOYMENT INFORMATION (SPOUSE OR GUARDIAN IF NO SELF EMPLOYMENT)

EMPLOYER'S NAME: _____

ADDRESS: _____

WORK NUMBER: _____OCCUPATION: _____

IN CASE OF EMERGENCY CONTACT:

NAME: _____ RELATION: _____

HOME PHONE: _____ WORK: _____ CELL: _____

PHYSICIAN INFORMATION

REFERRING DOCTOR: _____ PHONE # _____

FAMILY DOCTOR: _____ PHONE # _____

WHO CAN WE THANK FOR REFERRING YOU TO US? _____

PAYMENT INFORMATION

CIRCLE ONE**:** CASH INSURANCE WORKERS COMP. MEDICARE
IF MEDICARE, HAVE YOU RECIVED HOME HEALTH CARE FOR THIS INJURY: YES/ NO
IF WORKERS COMP. DO YOU HAVE AN ATTORNEY? YES/ NO
IF YES, WE NEED ATTORNEYS'S NAME, ADDRES& PHONE NUMBER:
_____

FINANCIAL RESPONSIBILITY: I HAVE READ AND UNDERSTAND NEO THERAPY'S 30 DAY POLICY. I UNDERSTAND THAT I AM UTIMATELY FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT NEO THERAPY ANY PORTION OF THESE CHARGERS NOT COVERED BY MY INSURANCE CO MUST BE PAID BY ME. I FUTHER UNDERSTAND THAT ALL INSURANCE DEDUCTIBLES ARE MY RESPONSIBILITY AND ANY DEDUCTIBLE APPLIED TO NEO THEARPY'S CHARGES WILL BE PAID DIRECTLY BY ME TO NEO THERAPY.
PATIENT'S SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NEO THERAPY.

PATIENT'S SIGNATURE: _____DATE:_____

AUTHORIZATION TO RELEASE INFORMATION: I AUTHORIZE NEO THERAPY TO RELEASE ANY INFORMATION REQUIRED BY MY INSURACE COMPANY.

PATIENT'S SIGNATURE: _____ DATE: _____

PLEASE NOTE: IF YOU ARE A MEMBER OF A MANAGED CARE INSURANCE, HMO OR PPO, IT IS YOUR RESPONSIBILITY TO KNOW YOUR POLICY PROVISIONS AND TO INFORM THIS OFFICE.