INSURANCE Information Form

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

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

_____ **Date of Birth** _____/_____/_____

Name: Last First Initial

Emergency Contact Name _____ **Number**(_____) _____-_____

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

_____ **Office Phone:** (___) ____-_____

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

_____

Address: Street City,State Zip Code

(3) If Filing Insurance :

If not the subscriber to insurance please complete below:

_____

Name of Subscriber: Last First Initial Sr./Jr.

_____

Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____ **Date of Birth**: _____/_____/_____
Home Mobile Work

Employed ____ Unemployed ____ Retired ____ Insured's Sex: M F

All Patients or Patients' Legal Representative Please Sign Section 6 on Page 2

INSURANCE Information Form

(4) 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 Madden Physical Therapy for All services delivered; if I am paid directly I will promptly pay Madden Physical Therapy all monies paid To me**

_____ **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 my insurer by the statement due date**

_____ **Certification of Information**

Initials **I certify that the information I have provided Madden Physical Therapy for payment including, but not limited to, Related accidents, illnesses or other insurers is accurate and truthful**

(5) Attendance Policy:

ATTENTION!

In order to provide our patients with the best possible care, we maintain scheduled appointments. *If you cannot make a scheduled appointment, PLEASE contact us 24 hours before your scheduled time.* This will allow us to adjust our schedule appropriately.

_____ATTENDANCE POLICY

Initials

Individuals who attend 100% of their scheduled appointments will receive a free MADDEN PHYSICAL THERAPY gift. ***PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISCHARGED.***

(6) Signature/ Date:

_____ _____

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

All Patients or Patients' Legal Representative Please Sign Section 6 on Page 2