MARANA PHYSICAL THERAPY LLC

PATIENT'S FULL NAME_____ MALE ☐ FEMALE ☐

DATE OF BIRTH_____-_____-_____ EMAIL_____ _____

HOME ADDRESS_____ CITY _____STATE___ ZIP_____

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE #_____

I GIVE AUTHORIZATION FOR THE FOLLOWING PEOPLE TO DISCUSS MY MEDICAL/FINANCIAL INFORMATION WITH THE STAFF OF MARANA PHYSICAL THERAPY:

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

EMERGENCY CONTACT: _____ TELEPHONE #_____

PLEASE CIRCLE THE APPROPRIATE RESPONSE(S) TO THE QUESTIONS BELOW TO ENSURE YOUR PRIVACY:

MAY WE LEAVE DETAILED PHONE MESSAGES ON ANY OF THE ABOVE LISTED NUMBERS? HOME WORK CELL NONE

PLEASE LIST ALL THE INSURANCE PLANS THAT YOU HAVE

• **RESPONSIBLE PARTY INFORMATION-----**

PRIMARY INSURANCE _____

POLICY HOLDER'S NAME_____ RELATION_____

POLICY HOLDER'S SSN ___- __ - ____ DOB: ____-____-_____

• **POLICY HOLDER'S EMPLOYER** _____**WORK PHONE #**_____ •

SECONDARY INSURANCE _____POLICY HOLDER_____

ID #_____ GROUP #_____

★**ARE YOU HERE BECAUSE OF *ANY* ACCIDENT, OR FALL? YES☐ NO ☐**

IF WORKER'S COMPENSATION OR MOTOR VEHICLE ACCIDENT – PLEASE COMPLETE THE FOLLOWING

CLAIM #_____ ADJUSTER'S NAME_____

DATE OF INJURY/ACCIDENT____-____-_____ ADJUSTER TELEPHONE #_____

NAME OF EMPLOYER _____

★**HAVE YOU HAD ANY OUTPATIENT PHYSICAL OR SPEECH THERAPY THIS YEAR? YES☐ NO ☐**

★**ARE YOU RECEIVING ANY TYPE OF HOME HEALTH CARE -- YES☐ NO ☐**

★**IF YES, NAME OF AGENCY THAT PROVIDED YOUR HOME HEALTH CARE: _____**

REFERRING DOCTOR_____ PRIMARY CARE PHYSICIAN_____

DIAGNOSIS (REASON FOR THIS APPOINTMENT) _____

HOW DID YOU HEAR ABOUT MARANA PHYSICAL THERAPY?

FRIEND ☐ YELLOW PAGES ☐ PHYSICIAN ☐ _____ OTHER: _____

☆**PLEASE READ AND SIGN - ASSIGNMENT AND RELEASE**:

I HEREBY AUTHORIZE PAYMENTS BE MADE DIRECTLY TO MARANA PHYSICAL THERAPY FOR ANY MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR MEDICAL SERVICES. I UNDERSTAND THAT IF MARANA PHYSICAL THERAPY AGREES TO BILL INSURANCE AS ACOURTESY TO ME I MUST SUBMIT INFORMATION AS NEEDED TO GUARANTEE PAYMENT FOR SERVICES RENDERED TO ME.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES. PAYMENTS ARE DUE 30 DAYS AFTER RECEIPT OF STATEMENT. LATE OR NON-PAYMENTS MAY RESULT IN COLLECTION PROCEEDINGS AND ASSOCIATED CHARGES. (PLEASE NOTE THAT MARANA PHYSICAL THERAPY IS NOT RESPONSIBLE FOR MIS-QUOTED BENEFITS BY YOUR INSURANCE COMPANY. WE RECOMMEND THAT YOU ALSO REFER TO YOUR INSURANCE HANDBOOK FOR CLARIFICATION OF BENEFITS RELATIVE TO OUTPATIENT PHYSICALTHERAPY).

I ALSO AUTHORIZE MARANA PHYSICAL THERAPY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

I HAVE RECEIVED THE WELCOME LETTER THAT ALSO INCLUDES AN OFFER OF THE MARANA PHYSICAL THERAPY NOTICE OF PRIVACY PRACTICES.

AS A MEDICARE PATIENT I HAVE RECEIVED A COPY OF MARANA PHYSICAL THERAPY'S DESCRIPTION OF THE MEDICARE THERAPY CAP.

SIGNATURE_____ DATE_____