DATE _____

PATIENTS LAST NAME_____ FIRST NAME_____

DOB_____ EMAIL ADDRESS_____ _____

SEX M / F AGE_____ MARITAL STATUS S___M___D____W____

ADDRESS_____ CITY_____ ZIP CODE_____

HOME PHONE_____ CELL_____ WORK_____

REFFERRING MD_____PHONE NUMBER_____

FAMILY MD _____ _____PHONE NUMBER_____

LAST DR. VISIT_____ DATE OF ACCIDENT_____

PRIMARY INSURANCE CO_____ NAME OF INSURED_____

POLICY # _____ GROUP #_____

INSURANCE PHONE #_____HOME CARE Y N DATE_____

SECONDARY INSURANCE_____ NAME OF INSURED_____

POLICY #_____ GROUP #_____

INSURED SS #_____ DOB_____

COMPENSATION CARRIER: NO FAULT CARRIER:

_____ _____

ADDRESS_____ ADDRESS_____
STATE_____ ZIP_____ STATE_____ ZIP CODE_____
DOI_____/_____/_____ DOA_____/_____/_____
EMPLOYER:_____ POLICY HOLDER:_____
CASE # _____ WCB_____ CLAIM/FILE _____
ADJUSTER_____ ADJUSTER_____
TELEPHONE #_____ TELEPHONE #_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS THIS CLAIM REQUIRED BY THE IMSURANCE CARRIER. I HEREBY AUTHORIZED PAYMENT DIRECTLY TO SOUTH SHORE PHYSICAL THERAPY FOR ITS SERVICES OR TREATMENT OF ILLNESS DESCRIBED. I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. SHOULD YOUR ACCOUNT BECOME PAST DUE AND ESCALATED TO A COLLECTION STATUS, YOU WILL BE RESPONSIBLE FOR THE INTEREST OF 1.5% PER MONTH, 18% PER YEAR WILL BE ADDEDTO ANY BALANCE DUE MORE THAN 30 DAYS BEYOND COMPLETETION OF TREATMENT. 33% WILL BE ADDED TO YOUR BALANCE TO COMPENSATE FOR LEGAL/COLLECTION FEES.

_____ _____

SIGNATURE OF PATIENT OR PARENT/ GUARDIAN IF MINOR DATE