



Admissions Form

Scheduled: _____ Time: _____ Therapist: _____

Patient Name: _____ M F Marital Status: S M D W

Address: _____
Street City / State Zip

Phone: Home: 202/301 _____ Work: 202/301 _____ Cell: 202/301 _____

SS# _____ - _____ - _____ DOB: ____/____/____ Employer _____

Referring MD: _____ Primary Care Physician: _____

Diagnosis : _____ Date of Injury or Onset: _____

INSURANCE

Policy Holder: Self / Other: _____ DOB _____

Relationship to patient: Spouse / Parent / Other: _____ SS# _____ - _____ - _____

Employer: _____

PRIMARY: Auto WC MC Commercial Insurance

Insurance Name: _____ ID / Claim # _____ Group _____
Address: _____ City _____ State/Zip _____
Phone: _____ Extension: _____ Adjuster: _____

SECONDARY: Auto WC MC Commercial Insurance

Insurance Name: _____ ID / Claim # _____ Group _____
Address: _____ City _____ State/Zip _____
Phone: _____ Extension: _____ Adjuster: _____

I have reviewed the above information. Other than any changes indicated above, I found the information to be correct. I have been informed of the above coverage verified and understand that this is only a verbal verification of benefits, NOT a guarantee of payment by my insurance company. This is NOT a guarantee of payment. I have been encouraged to independently verify my own insurance.

Patient Signature: _____ Date: _____

Office Use Only

Contact Name: _____ Effective Date: _____ Type: PPO HMO POS O _____

Network: In / Out Open Claim: Y N Out of Pocket: _____

Requirement with Claims: _____ Referral required: Y N

In Network: Deductible:\$ _____ Met:\$ _____ Coverage: _____% Copay: _____ Co-Ins: _____%

Out-of Network: Deductible:\$ _____ Met:\$ _____ Coverage: _____% Copay: _____ Co-Ins: _____%

Limits to Policy: _____

Verified on _____ Time: _____ By: _____