Location_____ DX code_____ Date of call _____ Eval_____

Patient Name _____ Maiden Name_____

What name would you like us to call you?_____

Street Address_____Mailing Address(if different)_____

City/State_____ Zip Code_____

Social Security Number _____ Date of Birth _____ Sex M F

Marital Status S M Employer _____ ***Student Y N***

Where can we contact you? ***If other than patient:*** ***Is it ok to leave a message?***

*Home Phone_____ask for_____ Y N

*Work Phone_____ask for _____ Y N

*Cell Phone _____ask for_____ Y N

Email _____

How early in the morning can we call you? _____***Area to be treated***_____

Whom may we thank for referring you? _____

Referring Dr_____PCP _____

Script Date _____ Date of next MD appointment _____ Surgery Y N Date:_____

Is this due to a (circle) **W/C** **MVA** **Liability** **N/A** Date of Injury/Onset _____

If MVA is circled, is there Medical Coverage on the *car you were in*? **YES** **NO**

YES? *provide billing information.* **NO?** *you will need to provide a letter from your Insurance stating there is no medical coverage.*

Is there an Attorney Involved? **Y** **N** Name_____ Phone _____

Primary Insurance Information

Insurance Company_____ Phone Number_____

Insurance ID/Claim # _____ Group Name/# _____

Policy Holder Name _____ DOB_____ SSN_____

Employer_____

Adjuster Name_____Phone Number_____

**DO YOU HAVE A SECONDARY INSURANCE? Y N If yes, please fill out back of sheet

Insurance Verification

******Verification of coverage is not a guarantee of payment. Carlson Therapy is not responsible for a misquote of benefit. Your patient responsibility will be processed according to the explanation of benefit received from your insurance company.***

For office use:

We verified with your insurance company the following information:

Spoke With _____ Effective Date _____

Claim Address _____

Deductible $_____ Met Y N Amt met $_____ OOP $_____ %_____

Copay $_____ Per Visit? Y N Referral Reqd? Y N Precert Reqd? Y N Orthonet Optum VIP

General benefit _____ Consecutive? Y N # Used_____

Misc. _____

_____

Secondary Insurance Information

Insurance Company_____ Phone Number_____

Insurance ID/Claim # _____ Group Name/# _____

Policy Holder Name _____ DOB_____ SSN_____

Employer_____

We verified with your secondary insurance company the following information:

Spoke With _____ Effective Date _____

Claim Address _____

Deductible $_____ Met Y N Amt met $_____ OOP $_____ %_____

Copay $_____ Per Visit? Y N Referral Reqd? Y N Precert Reqd? Y N Orthonet reqd? Y N

General benefit _____ Consecutive? Y N # Used_____

Approval/Dates _____ to _____ Auth #_____

Misc. _____

**It is recommended that you call your insurance company to verify your benefit. Making sure that both the patient and clinic have been told the same benefit information will help eliminate any surprises down the road.
**If your Insurance requires a referral, it is your responsibility to make sure it is in place before and during your treatment. Our office will fulfill any requirements for pre-certification within the scope of our contract.

You will be expected to make payments of ***$_____ per visit****.* ***We do not bill for co-pays.*** *Please be prepared to bring this amount to each and every visit and stop at the front desk to make your payment even if you are not asked to do so.*
If your appointment is scheduled during a time when the front desk is not open, leave payment with the therapist. Your account will be credited accordingly and a receipt will be mailed to you at your request. ***If this payment is toward a deductible or co-insurance, the amount due is only an estimate.*** *You will be balance billed for any remaining balance due once we are notified by your insurance company. You will be refunded in the event of an overpayment.*

If your minor child will be attending his or her therapy appointment without you, please send payment in with them.

By signing below, I acknowledge that I will make payment at each visit. I hereby agree and give consent to medical treatment necessary in treating my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible for any non-covered charges. Should my Insurance change during the course of my treatment I will provide the office with all necessary information to process my claim. Should I fail to provide this information and claims are denied as a result, I will be responsible for the denied visits. I authorize payment directly to the Carlson Therapy Network.

Signature_____ Date_____
Relationship to Patient_____

For minor child:
I hereby allow my child to be treated at Carlson Therapy Network without my presence.

Signature:_____Date_____
Relationship to Patient:_____
Office use only

Bring Script_____What to wear_____ Length of Appointment_____Bring Insurance Card_____
Check Their Insurance for Benefits_____ We DO DO NOT Participate _____
Best time to come in_____
MISC NOTES_____

09/09/10cdb