DATE:_____REFERRING DOCTOR_____Been here before? yes/no

PATIENT INFORMATION

Last Name:_____ First_____ M.I._____

Address, City, State, Zip:_____

E-Mail Address:_____ Spouse's Name:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Date of Birth:_____ Sex: M_____ F_____ SS#:_____

Is this a work related Injury? Yes____ No____ Date of Injury:_____

Is this an auto accident related Injury? Yes_____ No_____ Is there an attorney involved? Yes_____ No_____

Area of Injury:_____

PATIENT WORK INFORMATION

Employer's Name:_____

Address, City, State, Zip:_____

Work Phone Number:_____ Ext.:_____ ID #:_____ Occupation:_____

MEDICARE INFORMATION

Medicare Number (if applicable)_____

PRIVATE INSURANCE INFORMATION

Is this your coverage: Yes____ No____ If no, whose name is covered_____

Your relationship to the insured:_____ Policy Number:_____

Group Number:_____ Subscriber Number:_____

Insurance Company Name:_____

Address, City, State, Zip:_____

Phone Number:_____

CANCELLATIONS & NO SHOWS

Please understand your practitioner has set time aside for your treatment. Please let us know at least 24 hours in advance if you cannot make your appointment or we will need to charge you $80.00

OFFICE POLICY & PATIENT OBLIGATION

- Your Insurance Company will be billed as a courtesy to you. Should your insurance company withhold or refuse to pay for any reason or at anytime, **you will ultimately be responsible for payment on your account.**
- **Deductible, Co-payments or percentages are your responsibility.**
- Supplies not covered by your insurance company are your responsibility.

I have read and understand the above policy. I agree to all conditions and obligations herein.

Signature:_____ Date:_____

Signature of Parent or Guardian if treating a minor:_____

SECONDARY INSURANCE

Insurance Company:_____ Insurance ID Number:_____

Name of Insured:_____ Relationship:_____ Group Number:_____

Phone Number:_____

AUTO INSURANCE

Name of Insured:_____

Auto Insurance Company Name:_____

Address, City, State, Zip:_____

Policy Number:_____ Claim Number:_____

Adjustor's Name:_____ Phone Number:_____

WORKER'S COMPENSATION

Employer's Name (at time of Injury)_____

W/C Insurance Name:_____ Phone Number:_____

Address, City, State, Zip:_____

Claim Number:_____ Adjustor Name:_____

ATTORNEY INFORMATION

Name:_____ Phone Number:_____

Address, City, State, Zip:_____

We file claims as a courtesy to you. However, if we do not receive payment within 90 days, you will be held responsible. The full balance is due upon receipt of invoice.

I, agree to pay my Deductible of $ _____ and/or Co-Pay or Patient Responsibility of $_____ per visit, due at the time of service.

AUTHORIZATION TO PAY Petaluma Orthopaedic and Sports Therapy (P.O.S.T.)

Assignment of Benefits

I hereby authorize my Insurance benefits to be paid directly to Petaluma Orthopaedic and Sports Therapy and I am financially responsible for non-covered services. I also authorize Petaluma Orthopaedic and Sports Therapy to release any information to process this claim.

Signature:_____ Date:_____