



<b>PATIENT INFORMATION SHEET</b>			
Account Number:		Date:	
Last Name:	First Name:	M.I.:	
Street Address:		P.O. Box (if applicable)	
City:	State:	Zip:	
Home Telephone:			
Date of Birth: (mm/dd/yyyy):	Social Security:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Sex: M___ F___
Employer:		Chart Number:	
Employer's Address:		Work Telephone:	
Referring Physician:	Telephone:	Primary Care Physician:	Telephone:
Date of Injury:	Comments:		

<b>PRIMARY MEDICAL INSURANCE INFORMATION</b> <i>Please check one below:</i> <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Motor Vehicle Accident   State: _____ <input type="checkbox"/> Health Insurance <input type="checkbox"/> Self (If this is a Workers' Compensation claim, please put the proper insurance carrier information below, otherwise please provide your primary health insurance information)			
<b><i>For Workers' Compensation claims only:</i></b> Claim or Case Number:			
Claim Adjuster's Name:		Telephone:	
Insurance Company:		Telephone:	
Street Address:		P.O. Box (if applicable)	
City:	State:	Zip:	
**Subscriber's Name:	Relationship to Patient:	Subscriber's Date of Birth:	
Insurance Group Number:	Insurance I.D. Number:	Subscriber's Social Security Number:	
Subscriber's Employer:			

\*\*If you have this policy through your spouse, parents or other sources, he or she will be the subscriber of your insurance policy.



**PLEASE ARRIVE 15 MINUTES EARLY FOR YOUR APPOINTMENT TO ALLOW FOR REGISTRATION TIME.**

As a courtesy our staff will contact each patient's insurance carrier to verify therapy coverage. We also encourage all patients to call their insurance carrier and verify Physical Therapy and/ or Occupational Therapy coverage prior to their first appointment. This will allow patients to verify if Rehab 3 at Marsh Brook is in network, and will ensure that any insurance information given to our office is correct. All patients are expected to come prepared with referrals from their Primary Care Physician (if applicable) and Referring Physician orders. Patients are also responsible for making any necessary deductible, co-payments or co-insurance payments each visit, based on their policy. Financial Assistance is available; please ask our front office staff for more information.

**Patients should use the questions below as a guideline when calling their Insurance Company.**

- Am I covered to receive outpatient Physical Therapy and/ or Occupational Therapy at Rehab 3 at Marsh Brook?
- Do I need to obtain a referral from my Primary Care Physician? (if yes, please read the back side of this form)
- Do I have a deductible to meet? Amount: \$ \_\_\_\_\_
- How much of my deductible has been met this year? Amount: \$ \_\_\_\_\_
- Do I have any visit limitations? \_\_\_\_\_
- Am I responsible for a percentage or a co-payment each visit? Amount: \$ \_\_\_\_\_
- If Occupational Therapy, will splints be covered? Yes \_\_\_\_\_ No \_\_\_\_\_

**Patients with Managed Care plans or patients required to obtain a referral from their Primary Care Physician, please read the back of this form for additional information.**

**Workers' Compensation Information**

**If this is a work-related injury, patients should use the questions below as a guideline when obtaining Workers' Compensation information from employers. Patients arriving without their information will be responsible for payment in full each visit.**

- Date of Injury: \_\_\_\_\_
- State where injury occurred: \_\_\_\_\_
- Employer Workers' Compensation Carrier information:

Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ P.O Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Adjustor (if known): \_\_\_\_\_

File Claim Number: \_\_\_\_\_

**Please bring this form completed with your insurance information to your first therapy appointment.**