Mill Run Plaza
493 Main Street
Suite 2F
Groton, MA 01450
p: 978-449-9772 f: 978-449-9778

PLEASE PRINT CLEARLY AND COMPLETE ALL ITEMS FOR PROPER PROCESSING OF YOUR CLAIM

SEC 1

NAME ______ FIRST ______ MI ______ LAST

ADDRESS ______ # STREET APT CITY STATE ZIP

DATE OF BIRTH ______

PHONE ______

SSN ______

SEX ☐ M ☐ F

CELLPHONE ______

EMAIL ADDRESS ______

DRIVER'S LICENSE # ______

STATE ______

EMPLOYER ______ NAME CITY STATE PHONE #

EMERGENCY CONTACT ______

PHONE ______

SEC 2

REASON FOR VISIT

WHAT IS YOUR MAJOR COMPLAINT? ______

DATE PAIN OR PROBLEM STARTED? ______ DATE

SEC 3

HOW DID YOU HEAR ABOUT US?

☐ MD REFERRED ______ PHYSICAN'S NAME

☐ MD REFERRAL LIST

☐ FORMER PATIENT ______ PATIENT NAME

☐ YELLOW PAGES

☐ INSURANCE PROVIDER WEBSITE

☐ ATTORNEY

☐ LIVE FREE PHYSICAL THERAPY WEBSITE

☐ INTERNET SEARCH ENGINE

☐ OTHER ______________________________

SEC 4

HIPPA NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

YOUR SIGNATURE BELOW IS ONLY TO ACKNOWLEDGE THAT YOU HAVE BEEN GIVEN A NOTICE OF OUR PRIVACY PRACTICES.

______ PATIENT SIGNATURE ______ DATE

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SEC 5

HEALTH COVERAGE

PRIMARY INSURANCE ____________ PCP ____________
NAME TEL #

INSURANCE ID # ____________

PRIMARY INSURED'S NAME ____________ DATE OF BIRTH ____________

ADDRESS (IF DIFFERENT FROM YOURS) ____________

RELATION TO THE INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE ____________ INS ID # ____________

SECONDARY INSURED'S NAME ____________ DATE OF BIRTH ____________

ADDRESS (IF DIFFERENT FROM YOURS) ____________

RELATION TO THE INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS FOR PHYSICAL THERAPY SERVICES. I WILL BE FULLY RESPONSIBLE FOR ANY COPAYS, DEDUCTIBLES, COINSURANCE OR BALANCE MY INSURANCE COMPANY DOES NOT COVER.

____
SIGNATURE DATE

SEC 6

AUTHORIZATION TO PAY PROVIDER & ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance carrier to issue the expense benefits allowed and payable to me under the terms of the insurance policy as payment for services rendered to me by Live Free PT.

I also hereby authorize and direct Live Free PT to release any and all information from my medical records related to my condition in order to process claims.

I verify that all the information provided is true and correct. I agree to promptly notify this clinic of any change in this information until my account is paid in full. I understand that my insurance will be billed as a courtesy and that I remain fully financially responsible for all charges that I incur.

Signature of patient ____________ **Date** ____________

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SEC 1 — **AUTO INSURANCE INFORMATION**

WHEN DID THE ACCIDENT HAPPEN? ________ DATE

NAME OF INSURANCE ________ PHONE # ________

POLICYHOLDER ________ CLAIM# ________

INS. ADJUSTER ________ EXT # ________

SEC 2 — **WORKER'S COMPENSATION INFORMATION**

NAME OF INSURANCE ________ DATE OF INJURY ________

CLAIM # ________ MANAGER AT WORK ________

W/C ADJUSTER ________

W/C INSURANCE PHONE # ________ EXT ________

SEC 3 — **ATTORNEY INFORMATION**

NAME OF FIRM ________

NAME OF ATTY. HANDLING CASE ________

ADDRESS ________ PHONE ________
STREET CITY STATE ZIP