Carnahan Therapy/The Work Center, Inc.

Patient Information Sheet

Patient's Name: ______________________________ **Gender: F M**

Address: ______________________ **City, State, Zip:** ______________________

Home Phone: ______________________ **Cell/Work:** ______________________

E-Mail Address______________________________ **I give you permission to leave messages for me (via Voicemail): *Y or N* and to communicate with me (via E-Mail): *Y or N*.**

Soc. Sec. No.: ______________________ **Birth date:** ______________________

Employer: ______________________ **Work Phone:** ______________________

Address: ______________________ **City, State, and Zip:** ______________________

Driver's License No.: ______________________ **Primary Physician:** ______________________

Next MD Appt: ______________________ **Referring Physician:** ______________________

==========================Insurance Information=====================

Co-payment Amount: $__________ (to be paid at time of service)

___ Primary Insurance:__________________
Address: __________________
City, State, Zip:__________________
Phone: __________________
Insured:__________________
I.D. No.:__________________
Group No.:__________________

___ Secondary Insurance:__________________
Address:__________________
City, State, Zip:__________________
Phone:__________________
Insured:__________________
I.D. No.:__________________
Group No.:__________________

Attorney: __________________
Address: __________________
City, State, Zip: __________________
Phone:____________Fax:__________
Contact Person: __________________

___ Work Injury?: Date of Injury: __________________
Employer at time of injury: __________________
Ins. Co. Name: __________________
Address: __________________
City, State, Zip:__________________
Phone:______________Fax:__________
Adjuster:__________________
Claim #:__________________

___ Auto Accident?: Date of Injury:__________________
Ins. Co. Name: __________________
Address:__________________
City, State, Zip:__________________
Phone:______________Fax:__________
Adjuster:__________________
Claim #: __________________
Policy #: __________________

In Case of Emergency Contact:
Name: __________________
Phone:__________________
Relationship:__________________

As a courtesy to you we will bill your insurance company. Please remember that we do not accept responsibility for collecting your benefits for you. It is your responsibility to understand your insurance benefits and preauthorization requirements. You may ask our staff for assistance in understanding your insurance. If you have a co-payment or share of cost, we require that you make weekly payments while your treatment is ongoing. **CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE!!** We accept cash, check, VISA or MasterCard.

I authorize Carnahan Therapy/The Work Center, Inc. to bill my insurance company on my behalf, release necessary medical records to my insurance company, and I authorize payment to be made directly to Carnahan Therapy/The Work Center, Inc. Cash payment at time of service or payment arranged with Business Office.

Signature: ______________________________ **Date:** ______________________