

New Patient Information Form for Melanie Massey Physical Therapy, Inc.

Patient Name:		Patient DOB:	
Patient SSN:		Diagnosis:	
Address:		Home Phone:	
City:		State, Zip:	
Check One: () Male () Female		Referring Physician:	

IF THE PATIENT IS A CHILD, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Father:	Mother:
Employer:	Employer:
Home Phone: ()	Home Phone: ()
Work Phone: ()	Work Phone: ()
Cell Phone: ()	Cell Phone: ()
SSN:	SSN:

In the event of an emergency, please contact the following:

Emergency Contact Name:	Emergency Contact Number:
Emergency Contact Name:	Emergency Contact Number:

Insurance Information – Assignment of Benefits

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Ins. Company:	Ins. Company:
Name of Policy Holder:	Name of Policy Holder:
Policy Holders Relationship to Patient:	Policy Holders Relationship to Patient:
Employer:	Employer:
Policy Holders SSN:	Policy Holders SSN:

Assignment of Benefits: In consideration of services rendered, I _____ hereby irrevocably assign and transfer to Melanie Massey Physical Therapy all rights, title and interest in the benefits payable for services rendered by this medical provider or practice provided in the above mentioned policy or policies of insurance or benefit and welfare plan benefits. Said irrevocable assignment and transfer shall be for the recovery on said policies of insurance or employee benefit plans, but shall not be construed to be an obligation on the part of this medical provider or practice to pursue any right or recovery. Provided, however, this assignment and transfer shall not take away my standing to make a claim, appeal claim denials or sue for benefits individually should coverage be denied by any insurance carriers or employee benefit plan. I hereby authorize the insurance companies or employee benefit plans herein listed above to pay directly to this medical provider or practice all benefits due under said policy or plan by reason of services rendered. I will pay this medical provider or practice for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policies or plans. A copy of this authorization shall be considered as effective and valid as the original. If after this assignment of benefits is executed, I receive directly from any insurer or welfare benefit plan payment for charges incurred, I agree to immediately pay all charges which remain unpaid without regard for the status of my account and whether or not demand has been made by the medical provider or practice.

I have reviewed the Assignment of Benefits and I completely understand, agree and accept the conditions outlined.

Signature of Patient/Legal Representative _____

Date _____

If the individual other than patient, relationship to patient: _____

Designation of Authorized Representative: I hereby designate this medical provider or practice to act as my representative during an insurance or plan benefits appeal in the event of a coverage denial. I understand that this medical provider or practice has the right to decline or accept the designation at the time the denial is received. If this medical provider or practice accepts this designation, the outcome of any appeal is not guaranteed and I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan regardless of the outcome of any appeal. If the medical provider or practice declines to accept this designation, I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan immediately on demand without regard for the status of any appeal.

I have reviewed the Designation of Authorized Representative and I completely understand, agree and accept the conditions outlined.

Signature of Patient/Legal Representative _____

Date _____

If the individual other than patient, relationship to patient: _____