Patient Information
(Please Print)

Name:_____ Social Security Number:_____

Street Address:_____ Home Phone: ( ) _____

City/State/Zip Code:_____ Work Phone: ( ) _____

Date of Birth:_____ (please Circle) Sex: M F Marital Status S. M D W Separated

Email Address:_____

Emergency Contact:_____ Relationship to patient :_____

Emer. Contact phone Number: _____ Pharmacy Name/ Location:_____

Referring Physician: _____Ref. Physician Phone Number:_____

Primary Insurance In formation

Primary Insured Name:_____

Social Sec. Number_____ Date of Birth:_____

Relationship of insured to patient Self Spouse Child Other_____

Insurance Company:_____

Ins. Co. Billing address:_____

Ins. Co. City/State/Zip code:_____

Policy/ member Number:_____ Group Number:_____

Secondary Insurance Information

Primary Insured Name:_____

Social Sec. Number_____ Date of Birth:_____

Relationship of insured to patient Self Spouse Child Other_____

Insurance Company:_____

Ins. Co. Billing address:_____

Ins. Co. City/State/Zip code:_____

Policy/ member Number:_____ Group Number:_____

Guarantor (Person responsible for payment)

Name:_____

Street address/ City/state/ zip code:_____

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Office use only MD UPIN:_____

Additional Information

Employment Status (please Circle) Full time Part time Retired Student Not Employed

Employed by :_____ Phone Number ( ) _____

Employer address:_____

Employer City/State/ Zip Code:_____

Workman's Compensation / Auto Accident/Personal Injury

If this visit is the result of an accident or Work related illness:

Date of accident / Illness:_____ Claim Authorization Number:_____

Case/Claim Number:_____ Liability/No fault number:_____

Case Worker Name:_____ Phone Number ( ) _____

Remarks:_____

_____

Terms of Services

1. Payment is due at the time of service unless patient is covered by approved insurance plan. This office accepts cash and checks and Credit Cards.
2. There will be a $15.00 charge for returned checks
3. In the event an account remain unpaid and it becomes necessary for this office to engage in collection action all costs incurred will be charged back to you (court fees, and interest and collection agency fees)
4. **Cancellation Policy**: a $50.00 charge will be assessed for appointments cancelled less than 24 Hrs of the scheduled appointment time including the incident of no show.

Assignment Release:

I, the undersigned assign directly to Muna Swairjo PT, CI, all medical benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid for by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient or Guardian:_____ Date:_____

Medicare Authorization:

I request that payment of authorized Medicare benefits to be made payable to Muna Swairjo, Pt, CI for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. For Medicare Assigned cases, the provider agrees to accept the charges determined of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Signature of Patient: _____ Date:_____