Office Use

F/C : ❑ INS ❑ MC ❑ SP ❑ DD ❑ DDS ❑ WC ❑ AA ❑ PI PMANPVL # _____

Included : ❑ Insurance Card Copy ❑ Employer Claim Form ❑ Referral / Script ❑ Massage

PATIENT INFORMATION

Thank you for choosing Physical Medicine Associates - Naperville. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information :

Today's Date : _____ Patient's Soc. Sec. # : _____

First Name : _____ M.I. : _____ Last Name : _____

Mailing Address : _____

Zip Code : _____ City : _____ State : _____

Home # : (_____)_____ Work : (_____)_____ Cell : (_____)_____

Date of Birth : _____ ❑ Male ❑ Female

Employer : _____ Email : _____

Referred By : ❑ Self ❑ Friend ❑ Insurance Carrier ❑ Primary Physician ❑ Other _____

INSURANCE PATIENTS

Please complete the following section and present your Insurance Cards.

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured:	❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Complete the following Insured information if *RELATION* is other than *SELF*.		
Insured's Name:		
Insured's Birthdate:		
Insured's Insurance ID:		
Male or Female:		
Employer:		

ACCIDENT PATIENTS

CLAIM FILING INFORMATION	
WORK COMP OR MEDPAY INFORMATION	*ATTORNEY INFORMATION*
Date of Injury:	☐ Attorney Only - no WC or Medpay Info
Insurance Carrier Name:	Name :
Carrier Address:	Address :
City, State, Zip:	City, State, Zip :
Adjuster's Name:	Contact :
Adjuster's Phone : ( )	Phone : ( )
Claim Number:	File No. :

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges; which may also include legal, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services. I understand that for any balance remaining on my account past 30 days, pursuant to Physical Medicine Associate's discretion, my account may be turned over to collections or there will be a monthly late fee assessed of $15 for up to 3 months, and after that time my account may be turned over to collections.

Patient Signature : _____ Date : _____