

PLEASE PRINT ONLY

The Therapy Network  
TTN  
PATIENT INFORMATION

STAFF MEMBER INITIALS \_\_\_\_\_

DATE \_\_\_\_\_ PATIENT ACCOUNT NO. \_\_\_\_\_ NP  UPDATE  WC

LAST	FIRST	M.I.	1st Date of Symptom _____
ADDRESS			On the job injury? Y/N    Previous Injury? Y/N
CITY	STATE	ZIP	Date of Injury? _____ Time of Injury? _____
TELEPHONE _____ D.O.B. ____/____/____			Motor Vehicle Accident (MVA) Y/N
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			In what USA State did accident occur? _____
SS# _____	AGE _____		Date of Accident? _____ Time of Accident? _____
EMAIL:			Body Area affected _____
REFERRING PHYSICIAN:	If Surgery: Date of last surgery _____		
ADDRESS	All Other: _____		
CITY	STATE	ZIP	PATIENT EMPLOYER (if patient is a minor, then parent)
TELEPHONE	FAX	EMPLOYER	
PRIMARY INSURANCE:	ADDRESS		
I.D. NO. #	GROUP NO. #	CITY	STATE    ZIP
POLICY HOLDER'S NAME:	OCCUPATION    TELEPHONE		
POLICY HOLDER'S EMPLOYER:	SECONDARY INSURANCE:		
SS# _____	D.O.B. ____/____/____	I.D. NO. #	GROUP NO. #
ATTORNEY INFORMATION (if attorney is involved)			POLICY HOLDER'S NAME:
NAME	SS#	DOB	POLICY HOLDER'S EMPLOYER:
ADDRESS	EMPLOYER ADDRESS		
CITY	STATE	ZIP	ADDRESS (if other than above)
TELEPHONE	FAX	TELEPHONE	
HOW WERE YOU RECOMMENDED TO THE THERAPY NETWORK?			
<input type="checkbox"/> DOCTOR <input type="checkbox"/> CASE MANAGER <input type="checkbox"/> INSURANCE REPRESENTATIVE			
<input type="checkbox"/> ADVERTISEMENT IN:   WAVY TV / MAGAZINE (CIRCLE ONE) <input type="checkbox"/> OTHER (PLEASE LIST) _____			
OFFICE USE ONLY		OFFICE USE ONLY	
CLAIM NO. _____	ADJUSTER _____	TELEPHONE _____	FAX _____
EMPLOYER CONTACT: _____		CASE MANAGER: _____	
TELEPHONE: _____		FAX: _____	

**HEALTH HISTORY**

YES	NO		YES	NO	
		CANCER			HERNIA
		HEART CONDITION			POOR CIRCULATION
		CARDIAC PACEMAKER			JOINT REPLACEMENT
		HIGH BLOOD PRESSURE			METAL IMPLANTS
		RESPIRATORY PROBLEMS			SENSATION PROBLEMS
		DIABETES			DERMATOSIS / SKIN
		TUMORS			BOWEL / BLADDER PROBLEMS
		ARTHRITIS			ARE YOU ALLERGIC TO HYDROCORTISONE?
		SEIZURES			ARE YOU ALLERGIC TO IODINE?
		ULCERS			ARE YOU ALLERGIC TO BEES?
		ARE YOU PREGNANT? (WOMEN ONLY)			OTHER?
		OSTEOPOROSIS			

NEAREST RELATIVE (in case of emergency)		
LAST	FIRST	M.I.
ADDRESS		TELEPHONE

I authorize The Therapy Network to be my personal representative, which allow The Therapy Network to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100 percent of my benefits, within (90) days of any and all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to The Therapy Network for acting as my personal representative.

I certify that the information given is true and correct to the best of my knowledge. I authorize treatment of the above named patient. I authorize payment of benefits to The Therapy Network for the services rendered. I accept responsibility for payment of all charges. I agree to pay attorney's fees of 33 1/3% associated with collections and all other costs of collections, in event of default. If a check is returned for any reason, a return check fee of \$25 will be assessed to the account. I agree to pay The Therapy Network all fees relating to a check returned for any reason. Permission is given to The Therapy Network to release any information as may be requested from an insurance company having insurance in force, or from another physician, or employer (if services are paid by them). The Therapy Network files most health insurances as a courtesy to you for being our patient. However, this does not mean that we participate with all insurance companies. Verification of benefits does not guarantee payment and I understand that my insurance policy is a contract between me and my insurance company, and that I am financially responsible to The Therapy Network. I understand that if my insurance company denies payment for medical supplies I will be held responsible for pay to The Therapy Network. A copy of this release will be as valid as the original.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTO ACCIDENT INFORMATION**

Insured Party's Name (if other than patient) \_\_\_\_\_ Ins. Co. \_\_\_\_\_  
 Policy # \_\_\_\_\_ Claim # \_\_\_\_\_  
 Adjuster's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Date Accident reported to Ins. Co. \_\_\_\_\_

**\*\* If other driver involved in accident was at fault**

Insured Party's Name (if other than driver) \_\_\_\_\_ Ins. Co. \_\_\_\_\_  
 Policy # \_\_\_\_\_ Claim # \_\_\_\_\_  
 Adjuster's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Date Accident reported to Ins. Co. \_\_\_\_\_

\*\*\*\*Health Insurance information and necessary referrals must be given to receptionist in addition to Auto Insurance information. If for any reason your Auto Insurance denies payment of your claims, your Health Insurance will be billed accordingly. Patient will be responsible for any co-pays/cost-shares under their Health Insurance contract for any services billed to their Health Insurance. If you have an attorney, we will gladly forward copies of your file to their office.

*Office Use Only*

\_\_\_\_\_ Attorney lien signed      \_\_\_\_\_ Insurance waiver signed