Patient Agreement & Information

Name: _____ Home Phone: ( ) -

Social Number: ____/ ____/ ____ Cell Phone: ( ) -

Address: _____ Work Phone: ( ) -

City: _____ State: _____ Birthday ____/ ____/ ____

Zip Code: _____

Marital Status: _____ Employer: _____

Refering Physician _____

We need to bill: Workman's Comp, Auto Accident, Health Insurance? Sex: M or F

Date of Injury ____-____-____ State where Injury Occurred: _____

Name of Claim adjuster: _____

Name of Insurance Company responsible for payment: _____

Address:_____City: _____ State: _____ Zip Code:_____

Phone # _____ Policy /Group or Claim # _____

Please describe your injury, how it happened, and where you hurt: _____

_____

If this is Health Insurance through your spouse, please fill out this section

Spouses Name: _____

Social Number: ____/ ____/ ____ Birthday ____/ ____/ ____

Employer name: _____ Phone: ( ) -

Insurance Co: _____ Phone: ( ) -

Group Number: _____

Address: _____

Assignment & Release; I hereby authorize Palmer Therapy Center to release any information required to process my claim. I also authorize payment of medical benefits directly to Palmer Therapy Center for services rendered.
I understand that I am financially responsible for all services not covered by my insurance or payment made directly to me by my insurance company. I understand that I will also be charged the maximum monthly interest rate allowed by Alaska State law. I am also responsible for all collection and or attorney fees that are related to collecting the balance due to Palmer Therapy Center. Palmer Therapy Center is not liable for any injuries, accident or items left in the office

Signature _____ Date: ____/ ____/ 09