



Account # \_\_\_\_\_

Office \_\_\_\_\_

Initial Contact \_\_\_\_/\_\_\_\_/\_\_\_\_

Initial Eval Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE COMPLETE ENTIRE TOP BOX**

**Patient Name (Last)** \_\_\_\_\_ **(First)** \_\_\_\_\_ **(MI)** \_\_\_\_\_ **email address** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Home Phone( )** \_\_\_\_\_

**SS#** \_\_\_\_\_ **Sex** **M** **F** **Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Marital Status** \_\_\_\_\_ **Work Phone ( )** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Address** \_\_\_\_\_ **Cell Phone( )** \_\_\_\_\_

**Insurance Holder Name(Last)** \_\_\_\_\_ **(First)** \_\_\_\_\_ **(MI)** \_\_\_\_\_ **Holder Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Holder Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_ **Home Phone( )** \_\_\_\_\_

**Insurance Holder Employer** \_\_\_\_\_ **Work Phone( )** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Insurance Holder SS#** \_\_\_\_\_ **Emergency Contact** \_\_\_\_\_ **Phone( )** \_\_\_\_\_

**Symptom Onset or Surgery Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Is this due to:** **Work** **Auto** **Other** **None** **Body Part:** \_\_\_\_\_

**Name of Referring M.D.** \_\_\_\_\_ **Address** \_\_\_\_\_ **Phone( )** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_ **Fax ( )** \_\_\_\_\_

**Ins. Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone( )** \_\_\_\_\_

**ID/Policy/Claim#** \_\_\_\_\_ **Group #** \_\_\_\_\_ **Effective Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**If W/C or Auto, Name of Case Manager or Adjuster** \_\_\_\_\_ **Phone( )** \_\_\_\_\_ **ext.** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **Policyholder Name** \_\_\_\_\_ **D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Ins. Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone( )** \_\_\_\_\_

**ID/Policy/Claim#** \_\_\_\_\_ **Group #** \_\_\_\_\_ **Effective Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*\*\*\***For Office Use Only**\*\*\*\*\*

**Diagnosis Codes** \_\_\_\_\_ **Therapist Code** \_\_\_\_\_ **Date of Rx** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Date of Verif** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Spoke with:** \_\_\_\_\_ **Deductible \$** \_\_\_\_\_ **Co-Pay \$** \_\_\_\_\_ **Co-insurance %** \_\_\_\_\_

**Precert needed?** \_\_\_\_\_ **Referral needed?** \_\_\_\_\_ **Max visits or Limitations** \_\_\_\_\_

**Authorization # and Number of Visits Approved** \_\_\_\_\_ **Any prior visits?** \_\_\_\_\_

**Secondary Benefits:** \_\_\_\_\_

**Authorization and Assignment of Benefits**

I hereby authorize Maryland SportsCare & Rehab, LLC to apply for benefits from my insurance carrier(s) listed above and further authorize payment directly to Maryland SportsCare & Rehab, LLC of the medical benefits, if any, otherwise payable to me for services rendered by Maryland SportsCare & Rehab, LLC.  
Medicare Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Maryland SportsCare & Rehab, LLC for my services furnished to me by Maryland SportsCare & Rehab, LLC. I authorize any holder of medical or other 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 hereby authorize Maryland SportsCare & Rehab, LLC to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of \_\_\_\_\_ (patient). Further, I authorize Maryland SportsCare & Rehab, LLC to disclose complete information concerning records regarding the illness or accident of \_\_\_\_\_ (patient) to any collateral source in the case of Medicare, the Social Security Administration and the Health Care Financing Administration that will pay part or all of said medical bills. I hereby waive on my behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclosure of confidential medical information.  
I understand that all bills for services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest, payor or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Maryland SportsCare & Rehab, LLC reserves the right to pursue delinquent accounts via third-party collection agencies or attorneys. In the event my bill is referred to collection, I agree to pay the pre-judgment interest, reasonable attorney fees, court costs and service of process costs to said physical therapist in addition to the amount owed for the services rendered.

**Estimated Portion Due from Patient:** \_\_\_\_\_

This Authorization and Assignment of Benefits is valid for all episodes of care rendered by any and all physical or occupational therapists and/or physical or occupational therapist assistants associated with Maryland SportsCare & Rehab, LLC.

X \_\_\_\_\_ (Seal) \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_  
Signature of Patient or Guarantor, if Minor

Relationship to Patient \_\_\_\_\_