# FULL RANGE PT & REHAB SERVICES

**Your Life. Your Goals. Your Way.**

**Intake Date:** **Completed by:**

**Service**: Full Range Housecall ___
Outpatient: Drexel Hill ___ Valley Forge ___

Patients Name: Phone No.: Date of Birth:
Alt. Phone No.:

House Address:

**Emergency Contact** Name: Phone No.:
Relationship:

**Private Pay:**

Private Pay Rate
Eval : $130
Revisits: $75

**Insurance policy numbe**r- Primary and Secondary (if applicable):

Primary Insurance: ID No.:
Notes:
Group No.

Secondary Insurance: ID No.:
Notes: Group No.

**If Workers Comp:**
Claim #: Date of Injury:
Workers Comp Insurance:
Adjuster Name: Phone No.:
Attorney Name Phone No.:
Employer: SSN:

**If Auto Accident:**
Claim # Date of Accident:
Covering Insurance:
Adjuster Name: Phone No.:
Attorney Name Phone No.:

**Doctors Name:** **Direct Access** Yes: No:
**Date of Therapy Prescription**:

**Body Region of Injury**: General- Ex. Shoulder, Back, Neck

How did you hear about us: Doctor, Social Media, Friend, etc.

**Schedule an Evaluation Date**:
**Therapist:**

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Notify caller that: we will review insurance benefits prior to the first visit and notify them of any updates:
Copay and/or Deductible

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**Health Insurance Verification Sheet**

Completed by:

Date of Verification: Patient Name: Patient DOB:

**Insurance Company Name:**
**Insurance** (Primary___ Secondary___):
ID No.: Group No.:

Insurance Phone: Insurance Fax:

Contact Person/Spoke With: _____
Reference No. to call: _____
Note: Only needed if verification was completed over the phone

**In Network:** Yes___ No ___
**Insurance Effective Date:** _____

**Policy Type:** Calendar ___ Contract___ Lifetime___

Co-Pay Amount: _____
Policy Limits: _____ Limits Used YTD: _____
Deductible: _____ Deductible Currently Met: _____
Out of Pocket Max: _____ OOP Currently Met: _____

Referral: Yes___ No ___ Pre-Auth: Yes___ No ___

Insurance/Patient Split: _____ / _____

Notes:

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**Insurance Company Name:**
**Insurance** (Primary___ Secondary___):
ID No.: Group No.:

Insurance Phone: Insurance Fax:

Contact Person/Spoke With: _____
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Note: Only needed if verification was completed over the phone

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Referral: Yes___ No ___ Pre-Auth: Yes___ No ___

Insurance/Patient Split: _____ / _____

Notes: