6180 Brockton Ave. Ste 102
Riverside, CA 92506

Up & Movin' Pediatric Therapy PC

PATIENT'S NAME_____ DATE_____
(LAST) (FIRST) (MI)
ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)
HOME PH#_____ SEX_____ DATE OF BIRTH_____

PRIMARY CARE PHYSICIAN_____PHYSICIAN PHONE#_____

INSURED'S NAME (if different from pt)_____ HOME PH#_____

DATE OF BIRTH_____ EMPLOYER_____ CELL PH#_____

PARENT NAME_____CELL PH#_____EMAIL_____

EMERGENCY CONTACT _____ ADDRESS_____ PHONE #_____

REFERRED BY _____ PHONE#_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE#_____
BILL ADDRESS_____ CITY _____ STATE _____ ZIP _____
INSURED'S NAME _____ ID# _____
GROUP # _____ HMO _____ PPO _____ PAYOR ID # _____
DEDUCTIBLE AMOUNT _____ AMOUNT MET_____ CO PAY AMOUNT _____ __
(100%, 80/20, ETC.)
MAX VISITS _____ VISITS MET _____ POLICY PERIOD_____ AUTHORIZATION NEEDED_____
EXCLUSIONS/LIMITATIONS_____
NOTES:_____
_____
_____
INSURANCE REP'S NAME _____ CONFIRMATION # _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE#_____
BILL ADDRESS_____ CITY _____ STATE _____ ZIP _____
INSURED'S NAME _____ ID# _____
GROUP # _____ HMO _____ PPO _____ PAYOR ID # _____
DEDUCTIBLE AMOUNT _____ AMOUNT MET_____ TYPE POLICY_____ CO PAY AMOUNT _____ ___
(100%, 80/20, ETC.)
MAX VISITS _____ VISITS MET _____ POLICY PERIOD_____ AUTHORIZATION NEEDED_____
NOTES:::_____
_____
_____

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR KNOWING MY BENEFITS AND FOR PAYING ANY UNPAID BALANCE FOR SERVICES RENDERED.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: **Up & Movin' Pediatric Physical Therapy, PC**

_____**(SIGNATURE OF PATIENT OR PARENT)**
Date: