DIRECT ACCESS THERAPY INC.

Patient Information

Name _____ _____ _____
Last First Middle Initial

Address _____ _____
Street Name and Number Apartment / Unit

_____ _____-_____
City State ZIP Code

Phone Number (1) (_____)_____Home / Mobile/Office

Phone Number (2) (_____)_____Home / Mobile/Office

Gender Male / Female **Date of Birth** _____/_____/_____
Month Day Year

Social Security Number _____-_____-_____

Reason for Visit _____

Referring Physician _____ **Injury Date** _____/_____/_____
Month Day Year

Employer _____ **Phone Number** (____)_____

Emergency Contact

Name _____ **Phone Number** (____)_____ **Relationship** _____

PLEASE PROVIDE AN OFFICIAL FORM OF IDENTIFICATION TO YOUR PROVIDER

DIRECT ACCESS THERAPY INC.

INSURANCE DETAILS

Primary Insurance

Patient's Name _____

Name of Insurance Company _____

Phone Number (_____)_____

Policy Holder's Name _____

ID Number - _____

Employer (if applicable) _____

Group / Site # _____

Effective Date _____

Secondary Insurance (if applicable)

Name of Insurance Company _____

Phone Number (_____)_____

Policy Holder's Name _____

ID Number - _____

Employer (if applicable) _____

Group / Site # _____

Effective Date _____

PLEASE PROVIDE PROOF OF INSURANCE TO YOUR PROVIDER

DIRECT ACCESS THERAPY INC.

INSURANCE DETAILS

Motor Vehicle Accident / Liability Insurance

Patient's Name _____

Name of Insurance Company _____

Insurance Company's Phone Number (_____)_____

Contact Person / Claims Adjuster _____

Contact Person's / Adjuster's Phone Number (_____)_____

Policy Holder's Name (if applicable) _____

Policy / Accident Claim Number _____

Date of Accident / Injury _____

Attorney's Name (if applicable) _____

Attorney's Phone Number (if applicable) (_____)_____

PLEASE PROVIDE DETAILED INFORMATION TO ASSIST WITH VERIFICATION AND CLAIMS SUBMISSION.

DIRECT ACCESS THERAPY INC.

INSURANCE DETAILS

Workers Compensation Insurance

Patient's Name _____

Employer _____

Employer's Contact Person _____

Employer's Contact Number (_____)_____

Employer's Address _____
Street Address

_____
City State ZIP

Name of Insurance Company _____

Insurance Company's Phone Number (_____)_____

Contact Person / Claims Adjuster _____

Contact Person's / Adjuster's Phone Number (_____)_____

Policy / Accident Claim Number _____

Date of Accident / Injury _____

Attorney's Name (if applicable) _____

Attorney's Phone Number (if applicable) (_____)_____

PLEASE PROVIDE DETAILED INFORMATION TO ASSIST WITH VERIFICATION AND CLAIMS SUBMISSION.