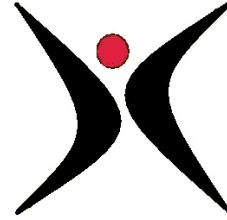


# DIRECT ACCESS THERAPY INC.



## 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** (\_\_\_\_) \_\_\_\_\_

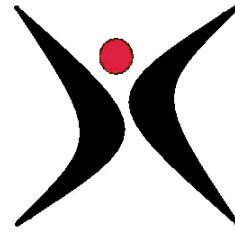
### Emergency Contact

**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 \_\_\_\_\_

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**Secondary Insurance (if applicable)**

Name of Insurance Company \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

ID Number - \_\_\_\_\_

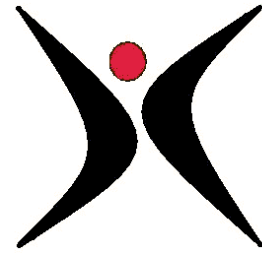
Employer (if applicable) \_\_\_\_\_

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 \_\_\_\_\_

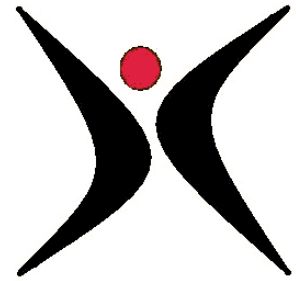
Date of Accident / Injury \_\_\_\_\_

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.