Reaper Physical Therapy, Inc.

Patient Information (Please Print) ☐ M ☐ F DOB: ______________________________

Patient Name: ____
(Last, First, MI)

Maiden/Previous Name: ________________ SSN ______________________________

Status: ☐ Child ☐Single ☐ Married ☐ Divorced ☐Widowed

Mailing Address: ____
(Street, PO Box, etc.)

______________________________ ______________________________
(City, State, Zip) (Home Address or Same)

Phone: (H)______________________ (C)______________________________

Employer______________________ Name of Bank______________________________

Spouse/Custodial Parent □ **Spouse** □ **Parent**

Spouse/Custodial Parent ____
(Last, First, MI)

☐ M ☐ F DOB:__________________ SSN:______________________________

Mailing Address: ____
(Street, PO Box, etc.)

______________________________ ______________________________
(City, State, Zip) (Home Address or Same)

Phone: (H)______________________ (C)______________________________

Employer______________________ Name of Bank______________________________

Additional Contact (Someone Not In Your Household)

Name:____
(Last, First, MI)

Phone: (H)______________________ (C)______________________________

Relationship: __________________ Address: ______________________________

Reaper Physical Therapy, Inc.

Insurance Information Primary Insurance Co____

Subscriber's Name: ______________________________ Eff Date___________________________

Sub. DOB: ________________ Group #____

ID #____________________________ Sub. SSN____

Secondary Insurance Co____

Subscriber's Name: ______________________________ Eff Date___________________________

Sub. DOB: ________________ Group #____

ID #____________________________ Sub. SSN____

Do not sign this agreement before you read and agree to the conditions set forth herein.

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements, promptly, unless credit arrangements are agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to my family or me. I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to Reaper Physical Therapy, Inc. all payments for therapy rendered to my dependent or me.

I also authorize the release of any medical or financial information necessary to process my claim(s). This release also includes CMS (Centers for Medicare and Medicaid Services). I authorize and request payment of medical benefits directly to Reaper Physical Therapy, Inc. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing. I agree that a photocopy of this form may be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents that may have a bearing on the benefits payable under this or any plan providing benefits or services. I certify the information is correct and true to the best of my knowledge.

Signed:____ Date_______________________________