Pacific Water Therapy

NEW PATIENT INFORMATION

Name: ______________________________ ______________________________
Last First

Address: ______________________________ City, State, Zip ______________________________

DOB: ______________ SS#: ______________ Email: ______________________________

Phone Numbers: ______________ (Home) ______________ (Work)

______________ (Cell) ______________ (Fax)

Emergency Contact: ______________________________ Phone ______________________

Who can we thank for your referral? ______________________________

Name of the Insured: ______________________________ Insured's DOB: ______________

Insured's Employer: ______________ Member ID#: ______________ Group#: __________

Diagnosis: ______________________________

Referring Physician: ______________________________ Phone ______________________

X-Ray Y or N MRI Y or N Date Last Seen By Physician ______________

Benefits verified by ______________ on ______________ at ______________

Is GOST IN Network for PT?	YES	NO
Referral or Pre-cert Required?	YES	NO
# for pre-auth is:		
Referral/Authorization #:		
Effective dates:		
# of visits authorized:		
COVERAGE	**In-network**	**Out-of-network**
Effective Date for Policy		
Deductible		
$ of deductible met		
Deductible based on calendar year?		
% paid by insurance after ded met		
Max out of pocket		
Co-pay or Co-insurance amt per visit		
RESTRICTIONS		
# visits allowed	Per year: Per diagnosis:	Per year: Per diagnosis:
Maximum $ amt per visit		
Maximum $ amt per year		
Procedures/modalities not covered:		
Limited # of procedures/modalities per visit:		
Medicare Patients: Has anyone recently or is anyone currently coming to your house to check your blood pressure, monitor wounds or diabetes, or any other services? YES NO		

Insurance Carrier: ______________________________

Billing Address: ______________________________

Phone: ______________________________ Fax: ______________________

Case Manager's Name: ______________________ Phone/Fax: ______________________

I have been given my insurance benefits and fully understand my responsibility. I understand that I am encouraged to contact my insurance company to verify that the benefits quoted to Pacific Water Therapy are correct. Pacific Water Therapy is not responsible for misquoted insurance benefits.

Signature of Patient and/or Legal Guardian______________________________