PATIENT INTAKE FORM

NAME: _____ **DOB**: _____ **SS#**_____

ADDRESS: _____ **CITY/STATE**: _____**ZIP**:_____

HOME PHONE: _____ **CELL PHONE**: _____ **E-MAIL:**_____

EMERGENCY CONTACT: _____ **PHONE:** _____**RELATION**: _____

INSURANCE BENEFIT INFORMATION

EFF. DATE:_____

Deductible: $_____ **Co- Ins:** _____/_____% **Copay: $**_____ RX? Y N

Met $: _____ Max $/ visits per cal year/ plan year: _____ Used? _____

Rem $: _____ Precert Req? Y N MC CAP $1920 USED _____ REM_____

If applicable, is home healthcare included in visit limitations? Y / N

Any Exclusions (CPT):_____

Spoke to/verified by: _____ DATE: _____

Call Reference number:_____

PATIENT / GUARDIAN SIGNATURE: _____ **DATE**: _____

Signing above certifies that the patient information is correct, any information changes are patients responsibility to notify office personnel, I understand that benefits are obtained as a courtesy; therefore, benefits given are NOT a guarantee of benefits or payment and are ultimately patient responsibility to fully understand their insurance guidelines, If claims are denied, or a change of benefit information is determined by your insurance, Revolution Rehabilitation, P.C. will not be held accountable for any accrued charges. **INITIALS**_____

OFFICE USE ONLY

TAX ID: 71-0877121 **MC: C806977** **NPI: 1578626248**

Primary Insurance: _____ Customer Service #: _____

Insurance ID#: _____ Group #_____

Primary Insured Name: _____ DOB: _____ Relationship to Patient _____

Secondary Insurance: _____Insurance ID #: _____

Auto/Workers Compensation

Company Name: _____ **DOI:** _____ ADJ: _____

Claim # _____ Ph: _____ Fx: _____

BILLING ADDRESS:_____

Employer Name:_____Address:_____

REFERRING DR._____**DIAGNOSIS**_____ **ICD-9**_____

SX DATE:

Referral Date:_____ Appt Date:_____ Therapist:_____ Computer? _____