Cross Roads Physical Therapy, LLC
1187 S. Main St.
Woodstock, VA 22664
Phone: (540) 459-7660
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Director: Matt Shiffler

Helping You Know Which Way To Go

Patient Information

Patient: _____ Date: _____
SSN: _____ Date of Birth: ___/___/___ Sex: ___M ___F
Home Address: _____City:_____Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____
Employer Address: _____
Occupation: _____
Single___ Married ___ Other: ___ Employed: ___ F/T Student: ___ P/T Student: ___
Spouse (or parent) name: _____
In case of emergency notify: _____ Phone: _____

Referring Physician: _____ Date physician last seen: _____
Date of Injury or first symptom: _____ Date of next MD appointment:_____
Is your condition related to: employment _____ motor vehicle accident: _____ other accident: _____

Worker's Compensation Information (on the job injury only) Date of accident: ___/___/___
Employer (at time of accident): _____
Employer address: _____
Employer phone: _____ Claim/Case #: _____

INSURANCE CARD REQUIRED – PLEASE GIVE TO RECEPTIONIST

PRIMARY INSURANCE company name: _____
Insurance Co. Address: _____
Insurance Co. Phone: _____ Contact:_____
Group #: _____ ID or Policy #: _____
Case Manager: _____ Case Manager #: _____
Subscriber's Information:
Name: _____ SSN: _____ Relationship to patient: _____
Address: _____ Date of Birth: __/__/__
Home Phone: _____ Work phone: _____

SECONDARY INSURANCE company name: _____
Insurance Co. Address: _____
Insurance Co. Phone: _____ Contact: _____
Group #: _____ ID or Policy #: _____
Benefits/deductible: _____
Subscriber's Information:
Name: _____ SSN: _____ Relationship to patient: _____
Address: _____ Date of Birth: __/__/__
Home phone: _____ Work phone: _____ (over)

I authorize release of any medical or other information necessary to process this claim.

I authorize payment of medical benefits to the supplier for services rendered. I understand that I am responsible to pay deductables and co-payments. I understand that the charges may be more than my insurance company will cover and I will be responsible for the balance due on my bill. Failure to make payment within 30 days of billing will result in a monthly fiance charge of 1.5%. Should I fail to carry out this agreement, the matter may be settled in District Court with all expenses added to my bill. If this account needs to be turned over to a collection agency, 40% of the account balance will be added for collection cost.

I have read and fully understand the above.

SIGNED: _____ DATE: _____

I authorize release of Medical Records to Cross Roads Physical Therapy.

SIGNATURE: _____ DATE: _____

The following is to be filled out only by patients with Medicare.

MEDICARE LIFETIME ASSIGNMENT

Name of Beneficiary_____
Medicare Number _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to Cross Roads Physical Therapy for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

SIGNATURE: _____DATE: _____