**VOB**

Date: \_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Marital Status: 🞏 Single 🞏 Married 🞏 Divorced 🞏 Separated 🞏 Widowed Sex: 🞏 F 🞏 M

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By checking the boxes below you are giving Redefining Health LLC permission to correspond with you via the following forms regarding any information needed for your physical therapy care .

Method of correspondence: 🞏 Phone 🞏 Email 🞏 Text 🞏 Voicemail to the above listed phone numbers

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .com

Primary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured 🞏 Self 🞏 Spouse 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_ If other or spouse please fill out next line.

Primary Insured First and Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance 🞏 Yes 🞏 No If Yes please fill out the following:

Secondary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured 🞏 Self 🞏 Spouse 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_ If other or spouse please fill out next line.

Primary Insured First and Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Redefining Health LLC. If payment from my insurance company should come directly to me I understand that it will be my responsibility to forward that payment to Redefining Health LLC for services rendered. I understand that I am financially responsible for any balance including but not limited to deductibles, copayments and coinsurances. I also authorize Redefining Health LLC, my insurance company or doctor’s office to release any information required to process my claims. I understand that Redefining Health LLC verifies my insurance benefits as a courtesy to me, however I am ultimately responsible for verifying my insurance benefits. This courtesy does not release me from full financial responsibility for services rendered by Redefining Health LLC.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Use Only:**

|  |  |  |
| --- | --- | --- |
| **Benefits – Outpatient PT** | **In Network** | **Out of Network** |
| Effective Date |  |  |
| Dr. Referral Required | Y/N | Y/N |
| Deductible | $ | $ |
| Deductible MET | $ | $ |
| Co Pay/CoInsurance | $ | $ |
| OOP Max | $ | $ |
| Maximum Visits/year |  |  |