PIVOT PHYSICAL THERAPY

Intake Form

Name _____ H phone_____

C phone_____

Email_____ W phone_____

Address _____

SS# _____ DOB_____ Employer_____

Referring MD_____ PCP_____

Body part (DX)_____ Accident type: none W/C Auto(state_____) Other DOI:_____

Prim Insurance_____ ph(as nec)_____ID#_____ group #_____

Policy holder_____ DOB _____ Employer_____

Sec Insurance_____Ins ph(as nec)_____ID#_____ group #_____

Policy holder_____ DOB _____ Employer_____

Insurance Verification

Primary:

Spoke to_____ Date____/____/____ Time_____ In network Y N Eff date_____

Coverage_____ pt responsibility_____$/% Deduct_____ met_____ OOP_____ met_____

Referral: Y N Precert: Y N MD script req'd: Y N Aquatics: Y N DME coverage: Y N

Visit max____ (circle one) /cond /cont yr /cal yr /lifetime /dx visit history____ limitations:_____

MC cap met Y N Amount used_____ MC Adv Plan Y N Home health care Y N

WC/Auto: Adjuster name_____ phone_____ fax_____

Secondary:

Spoke to_____ Date____/____/____ Time_____ In network Y N Eff date_____

Coverage_____ pt responsibility_____$/% Deduct_____ met_____ OOP_____ met_____

Referral: Y N Precert: Y N MD script req'd: Y N Aquatics: Y N DME coverage: Y N

Visit max____ (circle one) /cond /cont yr /cal yr /lifetime /dx visit history____ limitations:_____

MC cap met Y N Amount used_____ MC Adv Plan Y N Home health care Y N

If MC exhausts is there coverage: Y N