

PROFESSIONAL THERAPIES OF ROANOKE, INC.

421 Third Street, SW, Roanoke, VA 24011

Billing Office (540) 982-2204

Please verify the following information:

PATIENT'S NAME: _____

ADDRESS: _____ (FIRST) _____ (MIDDLE) _____ (LAST) _____ CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE NO.: _____ SOCIAL SECURITY NO.: _____

PATIENT'S BIRTHDATE: _____ AGE: _____ SEX: M/F _____

PATIENT'S MARITAL STATUS: (check one) single _____ married _____ separated _____ divorced _____ widowed _____

Please provide the following:

RESPONSIBLE PARTY NAME AND ADDRESS IF OTHER THAN PATIENT'S: _____

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY: (check one) self _____ spouse _____ child _____ other _____

EMPLOYER: _____ E-MAIL ADDRESS: _____ (Parent if patient is a minor)

EMPLOYER ADDRESS: _____ WORK TELEPHONE NO.: _____

NAME OF SPOUSE: _____ (Parent if patient is a minor)

SPOUSE EMPLOYER: _____ WORK TELEPHONE NO.: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____ TELEPHONE NO.: _____

REFERRING DOCTOR: _____

WORKMAN'S COMPENSATION CLAIM INJURY INFORMATION

DATE OF INJURY: _____ CLAIM NO.: _____

WORKMAN'S COMPENSATION CARRIER NAME, ADDRESS AND TELEPHONE NO.: _____

CLAIM ADJUSTER'S NAME: _____

PATIENT'S CONSENT AND FINANCIAL RESPONSIBILITY

I hereby authorize Professional Therapies of Roanoke, Inc. to obtain/release information needed to process and collect on my worker's compensation claim, and/or to gather pertinent medical documents to insure my safety. I understand that I have the right to revoke this authority at anytime by doing so in writing. In the event that my worker's compensation claim is denied, I will provide Professional Therapies of Roanoke, Inc. my medical insurance information and understand that I will be responsible for any balance that is not paid by my insurance company. I hereby consent to the treatment prescribed by my physician. I have received a copy of the PTOR Attendance Policies and Procedures and am willing to accept responsibility to follow these guidelines concerning attendance at therapy sessions.

Signed: _____ Date: _____

As a patient of Professional Therapies, Inc. I have been provided with a copy of Professional Therapies notice of Privacy Practice to be reviewed. I have been informed that should I have questions regarding Professional Therapies Privacy Policy or do not understand information in the policy that I may direct these questions to a Compliance Officer. If I choose, I may request a paper copy of the notice for my personal records.

Signed: _____ Date: _____