1105 Independence Drive
West Plains, Missouri. 65775
Phone: 417-372-8090
Fax: 417-256-0882

Patient Information

Name: _____
(First Name) (Last Name) (Middle Initial)

Address: _____

_____
(City) (State) (Zip Code)

Home #: _____Cell #: _____Work #: _____

Email Address: _____

Place of Employment: _____ Occupation: _____

Pease Circle: Single Married Legally Separated Divorced Widowed

Emergency Contact: _____. Phone #: _____
Relationship to Patient:_____

How did you hear about us?_____

How would you like to receive information from us? (Circle one). Text. Call. Email.

Insurance Information

Name of Insurance:_____

Name of Insured:_____. Relationship to patient:_____

Social security # of Insured: _____-_____-_____. Date of Birth of Insured: _____/_____/_____

Workman's Compensation

Work comp Claim? Yes____No____If yes, date of injury_____/_____/_____

Work comp Insurance Co. Name_____Adjuster Name_____

Claim#_____Phone#_____Fax#_____

Auto Accident

Have you been seen for PT/OT or Chiropractor during the calendar year? Yes_____NO_____

Who is the responsible party? Legal guardian if a minor?_____

Date of Birth____/_____/_____Phone#_____SSN_____

Address_____

Will you be paying today by: Cash____Check____CC____

Please provide proof of insurance coverage upon completion of this form.
Assignment and Authorization: I authorize the release of any medial information necessary to process insurance/Medicare claims on my behalf. I authorize payment of medical benefits directly to Progressive Therapy Solutions, LLC for services and supplies provided to me. A copy of this authorization shall be considered as valid as the original and valid for the duration of my care. I understand I am eligible for all charges incurred should my insurance not pay for these services (Except for Workers' Compensation).

_____ _____

Signature Date