



CACTUS SPORT & SPINE, P.C.

Therapist: _____ Acct #: _____ Date/Time of Evaluation: _____

PATIENT INFORMATION

Name: _____ Home # _____ Work # _____ Cell # _____

E-Mail: _____ SSN# _____ D.O.B. _____ Marital Status _____

Address _____
Street Apt # City State Zip

Employer Name/Address _____

Primary Care Physician _____ Referring Physician _____

Diagnosis or Chief Complaint _____

IN CASE OF EMERGENCY WHO SHOULD WE CALL?

Name: _____ Home # _____ Work # _____ Cell # _____

INSURANCE INFORMATION/VERIFICATION

Insurance Name _____ HMO PPO POS WC AUTO Injury Date _____

Insurance Phone# _____ Policy/Group # _____ ID/Claim# _____

Insured Name _____ SSN _____ D.O.B. _____

Adjustor Name _____ Phone # _____

Date Verified _____ Verified by _____ Person giving info _____ Effective Date _____

IN NETWORK

Deductible _____ Met _____ CoPay _____

% Insurance _____ Out of Pocket _____

Limitations _____

OUT OF NETWORK

Deductible _____ Met _____ CoPay _____

% Insurance _____ Out of Pocket _____

Limitations _____

Special Instructions / UR Process _____

Terms of Agreement: The following terms are based on information given to us at the time of evaluation. If you have any questions regarding the accuracy of these terms please contact your insurance company.

Acknowledgement: I (the undersigned) acknowledge the Privacy Notice as presented by Cactus Sport and Spine. I acknowledge that I may discuss or disagree with the Privacy Notice and this will not interfere with my treatment.

Assignment of Benefits: This is a direct assignment of my right and benefits under this policy. In the event the insurance company makes check(s) payable to me, I will endorse the check(s) and present them to the bookkeeper within 7 days of receipt.

Signature (Patient/Guardian) _____ Date _____