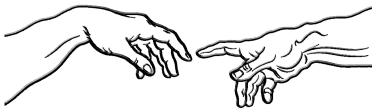
PRESERVA
THERAPY GROUP



931 Mall Ring Road
Sebring – FL – 33870
T: +1 863 314 8940

PATIENT INFORMATION

PT.# _____

Name: _____ **DOB**: / / **S**ex: (M) (F)

Address: _____ **C**ity: _____ **S**tate: _____ **Z**ip Code: _____

Home **P**hone: (_____) _____ - _____ **E**mail: _____

Mobile **P**hone: (_____) _____ - _____ **C**arrier _____ **SSN**: _____

Status: ☐S ☐M ☐D ☐W **W**ork Status: ☐Employed ☐Unemployed ☐Retired ☐Student

Emergency Contact: _____ **R**elationship: _____ **P**hone: _____

How did You hear about Us? _____

Is an attorney handling your case? (Y) (N) If yes, who? _____

Patient's Physician name: _____

City: _____ **S**tate: _____ **D**id **H**e refer You to Us: (Y) (N)

When was your last Dr. Visit for this condition? _____ **W**hen is your next Dr. Visit? _____

Are you currently receiving or have you received any Therapy this year? (Y) (N) If Yes from Who? _____

Insurance Information Insured Party: ☐Self ☐Spouse ☐Child ☐Parent

Name of 1° Insured: _____ **DOB**: / / **SSN**: _____ **S**ex: (M) (F)

Address: _____ **C**ity: _____ **S**tate: _____ **Z**ip Code: _____

Phone: M (____) _____ - _____ H (____) _____ - _____ **E**mail: _____

Primary Insurance: _____ **P**olicy #: _____ **G**roup #: _____

Secondary Insurance: _____ **P**olicy #: _____ **G**roup #: _____

Employer Information (Please complete if the insured person's employer is the source of benefits)

Company Name: _____ **C**ompany Phone #: _____

Address: _____ **C**ity: _____ **S**tate: _____ **Z**ip Code: _____

Authorizations

- ☐ I authorize that the payment of my insurance benefits be made directly to Preserva Therapy Group Inc. for all services delivered. If I am paid directly I will promptly pay Preserva Therapy Group Inc. all monies paid to me.
- ☐ I understand that all payments designated as "the patient's responsibility" such as co-pays/co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date.
- ☐ I certify that the information I have provided Preserva Therapy Group Inc for payment and/or under the Social Security Act (Medicare), including but not limited to related accidents, illness, or other insurers is accurate and truthful.
- ☐ I acknowledge that I was provided a copy of the "Notice of Privacy Practices" from "Preserva Therapy Group Inc", for me to keep and I have had an opportunity to read and understand the notice. This acknowledgement is requested per Government Statute.
- ☐ I authorize communication to me from Preserva Therapy Group Inc. of non protected information regarding scheduling and account information to the above specified: ☐Email ☐Address ☐Home Phone ☐Mobile Phone ☐Text ☐Message

_____ _____

Patient or Legal Rapresentative's **S**ignature **D**ate