MOUNTAINLAND THERAPY & ASSOCIATES P.C.

62801 US Highway 40 Granby CO 80446
(970) 887-2733 Fax (970) 970-887-0133

PATIENT INFORMATION

PATIENT NAME:_____D.O.B.:_____/____/_____ Sex:____
(first - middle initial - last)

MAILING ADDRESS _____
(PO BOX in most cases) city state zip

HOME/MOBILE PHONE: (____)_____ OTHER/WORK :(____)_____

EMPLOYER: _____
(name) (number) (address)

MEDICAL INFORMATION: **(please bring in prescription for therapy to first appointment)**

Referring Doctor:_____ Phone # (_____)_____

Diagnosis (what are we helping you with?) _____

Date of Injury_____ Date of Surgery_____

(Leave line below blank. To be filled out by provider)

Dr. NPI _____ DX/ICD:10 _____

BILLING INFORMATION **(present insurance card(s) at first appointment)**

INSURANCE TYPE: WORK COMP___MEDICARE___ PRIV INS (Co.name)_____

Insurance Company: _____Adjustor:_____

Phone #: (_____)_____FAX #: (_____)_____

Address _____

Group/Claim #_____Policy ID#_____

Name of Insured:_____ Insured's birthday: ____/____/____ Sex:___

Relationship to Insured:_____ Insured's Employer:_____

I authorize the release of information necessary to process my insurance claims and for payment to be made directly to: Mountainland Therapy and Associates. *NOTE:* I agree to pay all co-payments required, deductibles and any portion that my insurance will not pay. If this account goes to collections, I will be responsible for all fees incurred. A $5.00 rebill fee will be added to patient balances 30 days past due.

SIGNATURE:_____DATE:_____