KIMBERLEE J. O'DONALD, P.T., P.C.

1330 WEST WASHINGTON STREET • GREENVILLE, MICHIGAN 48838

Patient Information

Email _____ ☐ Male ☐ Female

Patient's Name _____ Social Security # _____

Address _____ Birthdate _____
Street

_____
City State Zip

Home Phone _____ Work Phone _____ Cell _____

If patient is a minor, give parent's or guardian's name _____

Who is the doctor who referred you to our office? _____ Phone _____

Family Doctor _____ Phone _____

Employment Information

Employer Name _____

Address _____
Street City State Zip

Phone _____ Supervisor _____

IS THIS INJURY COVERED BY WORKER'S COMPENSATION? ☐ YES ☐ NO

Auto Insurance Information

IS THIS INJURY CAUSED BY AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO

Auto Insurance Company _____ Claim # _____

Address _____
Street City State Zip

Phone _____ Contact Person _____ Insured's Name _____

Medical Insurance Information

Insurance Company _____ Phone _____

Insured's Name _____ Insured's Birthdate _____

Insured's Contract # _____ Insured's Group No. _____

Do you have dual coverage? ☐ Yes ☐ No If yes:

Insurance Company _____ Phone _____

Insured's Name _____ Insured's Birthdate _____

Insured's Contract # _____ Insured's Group No _____

RELEASE CONSENT

I hereby authorize release of any information, including reports of diagnosis, treatment, prognosis, reports, recommendation, benefits payable, as well as any other data pertinent to my treatment to the physician who referred me for therapy, and/or to any organization responsible for payment of my account (either insurance company or government agency). I acknowledge and understand that I am responsible for all of the charges for services rendered to me by Kimberlee J. O'Donald, P.T., P.C.. Although I requested that services be billed to the responsible organization on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason any portion of my bill is not paid by the responsible organization, I further agree to make arrangements for prompt payment of the bill. I understand that if collection action should become necessary for recovery of any monies due for services rendered, I agree to pay any and all collection costs of up to 40%, court costs, and reasonable attorney fees. I hereby authorize the responsible organization to pay the proceeds of any benefits due me directly to Kimberlee J. O'Donald, P.T., P.C.. A copy of this can be considered as an original for insurance purposes and valid as an original.

Signature: _____ Date: _____

TO ALL WORKER'S COMPENSATION PATIENTS

If Worker's Compensation insurance coverage can be verified, all patients treated by our office for injuries sustained while on the job will have their treatment charges billed directly to the insurance carrier. Prior to treatment under this classification; employment, insurance coverage and all information pertaining to your claim will be verified. It is the responsibility of the patient to furnish our office with the necessary information and name (s) in order for our office to verify coverage. **Note: If your Worker's Compensation claim is in litigation, a Letter of Guarantee from you and your attorney will be necessary in order for this office to hold your account balance in pending until settlement is reached, otherwise you will be treated on a CASH ONLY basis. Our office will also request your personal insurance carrier information. When a settlement is reached, payment will then be DUE IMMEDIATELY. It is the responsibility of the patient to pay their balance at the time of the settlement whether or not the settlement is in your favor.

If I have an EMERGENCY please call:

_____ _____
(Relationship) Phone

_____ _____
(Relationship) Phone