CCM INTAKE SHEET

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Doctor's Office **DR.**

CONFIDENTIAL PATIENT INFORMATION

Last name _____ _____ First _____ Male/Female
Street address _____ _____
City _____ _____ State _____ Zip _____
Home phone _____Work _____ Cell_____ E-mail_____
Social Security # _____Date Of Birth _____
Date of injury _____ Date of consultation _____
DIAGNOSIS _____
(check one) Insurance _____ Personal injury _____ Work comp. _____ Cash _____
Excess Medpay Y/N Medpay Y/N 3rd Party Y/N U.M. Y/N Attorney Lien Y/N (applies to PI cases)
Name And Address Of Attorney_____

Insured's name _____ PT. ID#_____ Relationship to pt. _____
Group # _____ Employer If W/C_____

Name of Insurance Co. _____
Street Address _____
City, State, Zip _____
Phone _____

Rep's Name _____ Date _____
"This is (name), I'm calling to verify out-patient physical therapy benefits, please"
Effective date _____
Deductible _____ Is it met ? Y / N How much _____
Percent of coverage ? _____ Out of pocket max. (stop loss) _____
Co-pay amount_____
Any pre-existing clauses / waivers Y / N
Is this an HMO? Y/N Who is the medical group?_____
If HMO, are there out of network benefits? Y / N

Any specific limits on physical therapy ? _____
# of visits per condition ? _____ Dollar amount per visit max.?_____
# of visits per year ? _____ Dollar amount per year max. ? _____

One other question please, are there any limitations on chiropractic care ?

# of visits per condition ? _____ Dollar amount per visit max. ? _____
# of visits per year ? _____ Dollar amount per year max. ? _____
Are these chiropractic benefits for spinal related conditions ? Y / N
What are the benefits for non spinal related conditions ?

Is massage therapy a covered benefit? (97124) Y/N