Patient Insurance Information: (please fill out form completely)

Patient name ____ Date ___________________________

Address: ____
PO Box/Street City State Zip Code

Sex: M F Date of Birth: ______/_______/_______ SSN: _________-___________-__________

Referring Physician: ____________________________ Primary Care Physician ___________________________

Responsible Party: Name: _________________________________ Date of Birth: ___/___/___ SSN: ____-____-____

Address: ____ Relationship: _______________
PO Box/Street City State Zip Code

Home phone __________________ Cell phone ___________________ Email __________________________

Employer: ______________________________________ Work phone ______________________________

Address ____
PO Box/Street City State Zip Code

Emergency Contact: Name ____

Relationship ________________________ DOB ____/____/_____ Phone ________________________________

Insured's Information:

Primary Insurance Company: ____________________________ Name of Policy Holder: _____________________

Address: ____
PO Box/Street City State Zip Code County

Date of Birth: _____/______/______ SSN: ______-______-_______ Relationship to Patient _________________________

Secondary Insurance Company: ________________________ Name of Policy Holder: _______________________

Address: ____
PO Box/Street City State Zip Code County

Date of Birth: _____/______/______ SSN: ____-____-_____ Relationship to Patient ______________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I verify that all information above is correct to the best of my knowledge. I authorize Dynamic Strides Therapy, Inc. and any individual therapists employed or contracted by Dynamic Strides Therapy, Inc. who furnish services to the above-named patient to release any medical information necessary to process claims associated with the above-named patient. I allow a copy of this authorization to be used in place of the original.

I assign to Dynamic Strides Therapy, Inc. and any individual therapists employed or contracted by Dynamic Strides Therapy, Inc. who furnish services to the above-named patient the right to bill for the services the above-named patient has received from Dynamic Strides Therapy, Inc., the right to receive payment for the same, and the right to pursue payment for the same, including, but not limited to the right to pursue administrative appeals, litigation, and/or other relevant causes of action in connection with the same.

____________________________________ ____________________

2673 E Sawyer Road • Republic, MO • 65738
Phone: 417-324-7646
Fax: 417-627-5542

dynamic strides
THERAPY

Responsible Party's Signature Date

2673 E Sawyer Road • Republic, MO • 65738
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