



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.



dynamic strides
THERAPY

Responsible Party's Signature

Date

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

Fax: 417-627-5542
KCP-8309701-1