C.O.R.E. Physical Therapy, PLLC
2440 M Street, NW, Suite 322
Washington, DC 20037

PATIENT INFORMATION **DATE:**

Patient's Full Name _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____ Email Address:_____

Home Phone _____ Work Phone _____ Mobile Phone _____

Birth Date_____/_____/_____ Age_____ Sex:___M ____F Marital Status ____M ____S____D

Referring Physician _____ **How did you hear about us?**_____

Diagnosis: _____ **Date of Injury/Accident: _____**

Employer's Name _____ Phone Number _____

Address _____

Occupation _____ Full-time _____ Part-time _____

Primary Insurance _____ Policy Holder's Name_____

Policy Holder's Date of Birth_____ Policy Holder's relationship to patient _____

Worker's Compensation / Auto Insurance Claim? Yes / No If Auto Claim: Date of accident _____ State ____

Adjuster's Name_____ Adjuster Phone_____

We will not accept assignment for auto accident claims

You are responsible for the payment of charges not covered by your health benefit plan at the time of service.
As a courtesy, we will submit your primary insurance claims (on your behalf) if the insurance information provided is correct and complete.

Signature _____ Date _____

AUTHORIZATION/VERIFICATION (FOR OFFICE USE ONLY)

Primary Plan Name: _____ Effective date of policy: _____

Pt. pays (%): _____ Ins. pays:_____ Deductible: _____ Amount met: _____

Out of Pocket limit: _____ Amount met: _____ Deductible year: _____

Agent's Name: _____ Date: _____

# of visits allowed: _____ # of visits used: _____ Needs pre-cert/Prior auth?: YES NO

Does Patient have secondary insurance? YES NO If yes, Plan Name: _____

Authorization

Date: _____ Agent's Name: _____Phone Number: _____

# of Visits: _____ Start Date: _____ End Date: _____ Authorization #: _____