Patient Information

Carolina Therapy Services

Name (First) _____ (MI) _____ (Last) _____

Date Of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D

Address: (Street) _____

(City, State, Zip) _____

Phone #: _____ Work#: _____ Mobile# _____

Social Security Number: _____ Emergency Contact Name/Number: _____

Email adress: _____

Guarantor/Responsible Party Information

Name (First) _____ (MI) _____ (Last) _____

Date Of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D

Address: (Street) _____

(City, State, Zip) _____

Phone #: _____ Work#: _____ Mobile# _____

Drivers License#: _____ Social Security Number: _____

Employer: _____

Employer's Address: _____

Primary Insurance Information

Insurance Co: _____ ID# _____ Group# _____

Insured's Name: _____ Relationship to patient ☐ self ☐ spouse ☐ dependent

Employer's Address: _____

Insured's Social Security #: _____ DOB _____ ☐ M ☐ F

Secondary Insurance Information

Insurance Co: _____ ID# _____ Group# _____

Insured's Name: _____ Relationship to patient ☐ self ☐ spouse ☐ dependent

Employer's Address: _____

Insured's Social Security #: _____ DOB _____ ☐ M ☐ F

I hereby assign, transfer, and set over to Carolina Therapy Services, Inc. all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Guarantor Signature: _____ Date: _____