1717 Shipyard Blvd., Suite 320
Wilmington, NC 28403
Phone (910) 791-0396
Fax (910) 791-0818
Email: Shorelinept@gmail.com

Shoreline PHYSICAL THERAPY
sport & spine specialists

Douglas A. Miller, PT, MSPT, SCS, Cert. MDT
Jerome A. "Jai" Isear, Jr., MS, PT, LAT, ATC
Stephen L. Bright Jr., LAT, ATC, Cert. MDT
Susanne L. Butler, PT

Patient's Name: Last _____ First _____ Middle Intitial ___

□ Male □ Female Age:_____

Birthdate:_____ SSN:_____

Address:_____

City, State, Zip:_____

Home Phone: (_____)_____-_____

Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____

Email:_____

Emergency Contact:_____

Relation:_____

Phone: (_____)_____-_____

Referred by:_____

Are you employed? □Yes □No How Long?_____

Occupation:_____

□ Full Time □ Part Time

Employer:_____

Employer Address:_____

City, State, Zip:_____

Employer Phone: (_____)_____-_____

Date of Injury:_____

□ Married □ Single □ Divorced

Spouse's Name:_____

Spouse's Employer:_____

Are you a student? □ Yes □ No

School:_____

PRIMARY INSURANCE / WORKER'S COMP

Carrier Name:_____

Address to mail claim:

_____

_____

_____

Phone: (_____)_____-_____

Policy # or Case #:_____

Group #:_____

Policy Holder's Name:_____

Policy Holder's Birth Date:_____

Patient's Relationship to Policy Holder:

□ Self □ Dependent □ Spouse □ Child

□ Other:_____

SECONDARY INSURANCE

Carrier Name:_____

Address to mail claim:

_____

_____

_____

Phone: (_____)_____-_____

Policy # or Case #:_____

Group #:_____

Policy Holder's Name:_____

Policy Holder's Birth Date:_____

Patient's Relationship to Policy Holder:

□ Self □ Dependent □ Spouse □ Child

□ Other:_____

Please give your insurance cards to the receptionist so that a copy can be made for our records. Thanks.

RESPONSIBLE PARTY (RP) INFORMATION

RP Name: _____
Address: _____
City, State, Zip_____
Home Phone: (_____)_____-_____
SSN: _____ Birth Date: _____

RP Occupation: _____
Employer: _____
Address: _____
City, State, Zip: _____
Work Phone: (_____)_____-_____

REASON FOR THERAPY: _____

Onset Date of Injury or Symptoms: _____

Insurance Assignment:

I, the undersigned, having insurance coverage, authorize assignment of all medical benefits, if any, directly to Shoreline Physical Therapy. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the staff at Shoreline Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

_____ _____

Signature of Insured or Guardian Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made on my behalf to Shoreline Physical Therapy for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned claims, Shoreline Physical Therapy agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

Authorization to Receive Therapy:

I hereby authorize treatment to be rendered by Shoreline Physical Therapy as prescribed by my physician.

_____ _____

Signature & Release for Treatment
(If minor, Guardian signature)

Date