# First Contact & Payment Verification

| Date of Contact | Staff Name | Appt. Time | Appt. Date |
|---|---|---|---|
| | | | |

**Condition**

| Area of pain/problem | | Date pain/problem began | |
|---|---|---|---|
| Mechanism of Injury | ❑ Work<br>❑ Auto<br>❑ Other | Date of similar pain/problem in past | |
| Impairments? ❑ Sleep ❑ Bathroom ❑ Sit ❑ Walk ❑ Other: | | ❑ Worsening<br>❑ Better<br>❑ Same | ❑ Hospitalized<br>❑ Missing work<br>Since when? |

**Patient Info**

| Patient Name (Last, First) | | Age | DOB | ❑ Male<br>❑ Female |
|---|---|---|---|---|
| Hm Phone | Other Phone | Email | | |
| Street Address | | City | | State & Zip |
| How did you hear about us? | | Social Security # | | |

**Payment Information**

PRI WC LIEN MC AUTO SELF-PAY (discount/CC info to reserve) PAY PLAN other:

| Insurance Company Name | | | Referring Physician | |
|---|---|---|---|---|
| Street Address | | | City | State/Zip |
| Subscriber Name (if other than self) | ❑ Parent<br>❑ Spouse<br>❑ Other | DOB | ID # | Group # |
| (WC only) Claim Number | Adjuster Name | | Phone # | Date of injury |
| Employer Name | | Occupation | Employer Phone | |
| Emergency Contact Name | | Relationship | Emergency Contact Phone | |

| Date of Verification | Staff Name | Comments: |
|---|---|---|
| | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PRI | Date of Eligibility | Copay $ | Deductible $ | Met $ | Coinsurance % | Maximums? | Notes: |
| WC | Date of Auth. | # Visits | Exp. Date | Auth # | | Person Auth | |
| Lien | Date Agreement sent | Attorney Name | | Address | | | Date of Accident |
| Auto | Third Party Name | | | Insurance Name | | Phone # | Claim # |
| Self | ❑ Visa<br>❑ MC<br>❑ Amer Ex | Name on Card | | Card # | | Exp Date | 3 digit code (on back) |

| Date of Verification | Staff Name | Comments: |
|---|---|---|
| | | |