Divine
Therapy & Wellness, LLC.
Striving for Excellence in Rehabilitation Care

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PATIENT INFORMATION

Social Security # _____-_____-_____

Patient Name: _____ Email: _____
(Last) (First) (M.I.) (For appointment purposes only)

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home ( ) _____-_____ Work ( ) _____-_____ Ext.____ Cell ( ) _____-_____
Date of Birth: _____/_____/_____ Sex: M F Marital Status: M S D W U
Employer Name and Address: _____

Responsible Party Information

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____
Name: _____
(Last) (First) (Middle)
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home ( ) _____-_____ Work ( ) _____-_____ Ext.____ Cell ( ) _____-_____
Social Security # _____-_____-_____ Date of Birth: _____/_____/_____

Physician Information

Referring Physician Name _____Office Address_____ _____
Primary Care Physician Name_____ –(if different from referring) Office Address_____

Insurance Information

Primary Insurance:

Carrier's Name: _____ Phone No. ( ) _____-_____
Address: _____ City: _____ State: _____ Zip: _____

Policy/I.D. #: _____ Group #_____ Group Name: _____
Authorization/Pre-Certification #:_____

Secondary Insurance:

Carrier's Name: _____ Phone No. ( ) _____-_____
Address: _____ City: _____ State: _____ Zip: _____

Policy/I.D.: _____Group #_____ Group Name: _____

Payment Agreement:

If for any reason my claim is denied and payment for physical therapy is stopped, I agree to pay in full any charges that are outstanding.

Signature: _____ Date: _____/_____/_____