E-mail Print

Insurance Information: **Click to E-mail or Print to Fax to: 843-757-9294**

Patient Information: Last Name: _____ First: _____ Middle: ___

Street Address:_____

City/State: _____ Zip Code: _____

Day Phone: _____ Evening: _____ Cell Phone: _____

DOB: _____ SSN: _____ Date of Illness/Accident/Surgery: _____

Email: _____

Patient Status: Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Employed: ☐ Retired: ☐

Employer: _____Contact:_____Phone:_____

Address: _____City/State:_____

Spouse: Last Name: _____ First: _____ Middle: ___

Street Address:_____

City/State: _____ Zip Code: _____

Day Phone: _____ Evening: _____ Cell Phone: _____

DOB: _____ SSN: _____ Date of Illness/Accident/Surgery: _____

Spouse Status: Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Employed: ☐ Retired: ☐

Employer: _____Contact:_____Phone:_____

Address: _____City/State:_____

Insurance Carrier:

Primary Insurance: _____ Phone: _____

Address: _____

City/State: _____ Zip Code: _____

ID#: _____ Policy #: _____ Group Policy # _____

Co-Pay: _____ Deductible: _____

Form Continued Next Page

E-mail Print

Insurance Information: **Click to E-mail or Print to Fax to: 843-757-9294**

Secondary Insurance: _______ Phone: _____

Address: _____

City/State: _____ Zip Code: _____

ID#: _____ Policy #: _____ Group Policy # _____

Co-Pay: _____ Deductible: _____

Primary Physician: Last Name: _____ First: _____ MI __

Address: _____

City/State: _____ Zip Code: _____

Phone: _____

Emergency Contact: Name: _____

Day Phone: _____ Other Phone: _____

***AS A COURTESY TO YOU*, WE WILL FILE YOUR PRIMARY CLAIMS BUT YOU ARE RESPONSIBLE FOR ANY NON-PAYMENT BY YOUR INSURANCE CARRIER**.

I, the undersigned, hereby authorize my insurance benefits to be paid to
Hilton Head Occupational Therapy
I acknowledge that I am financially responsible for all NON-COVERED services.
I hereby **authorize my physician to release any information** to support my claim.
I also agree that a photocopy of this document will be deemed valid and binding.
I hereby **authorize Hilton Head Occupational Therapy** to act as my agent and to help me secure payment from my insurance company.

Please FAX to: (843) 757-9294

Signature: _____ Date _____