Specialized Therapy Services

890 Elm Grove Rd STE 1-1
Elm Grove, WI 53122
Phone: 414-778-1341
Fax- 262-794-3888

Intake Form (Page 1 of 2)

Please print all information clearly. Please fill out only those sections that apply to your case.

Personal Information

Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Cell Telephone: (____) _____ Email: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: _____

Marital Status: S M W D Emergency Contact Name & Phone: _____

***Please note**: Social Security Numbers are required to bill insurance*

Employment Information

Occupation: _____ Employer: _____

Employer Address: _____
Street City State Zip

Employer Phone: _____ Ext. /Dept. _____

Medical Information

Reason for being seen: _____

Date of injury or onset: _____ Related to work: ____yes ____no
Auto accident: ____yes ____no
Other: ____yes ____no

Please explain how injury occurred: _____
_____
_____

Who referred you to our clinic? _____

Attorney Information

***Please note:** Policies for personal injury cases are available upon request. If your case is sent to an attorney please inform your therapist immediately.*

Name of attorney representing you: _____

Attorney's firm name: _____

Attorney's FULL MAILING address: _____
_____

Attorney's phone: _____

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Worker's Compensation Injury Billing Information

Please Note: *Complete information is needed in order to process your claim.*

Name of employer: _____

Address of employer: _____
Street City State Zip

Phone # of employer: _____

Worker's compensation insurance carrier: _____

Address of carrier: _____
Street City State Zip

Adjuster's name: _____ Adjuster's phone: _____

Claim #: _____

Auto Accident Injury Billing Information

Please Note*: Complete information is needed in order to process your claim.*

Name of no-fault insurance company: _____

Name of the policy holder: _____

Relationship to the policy holder (self, spouse, child, other) _____

Address of insurance company: _____
Street City State Zip

Ins. company phone #: _____ Adjuster's name: _____

Policy #: _____ Claim #: _____

Major Medical Billing Information (*A copy of your insurance card will be needed to verify this information)*

Major health insurance carrier: _____

Carrier address: _____
street city state zip

Carrier phone #: _____ Name of insured: _____

Insured I.D. #: _____ Group/Policy # of insured: _____

Release, Lien and Assignment

I hereby consent and authorize the administration of all procedures/treatment and authorize Specialized Therapy Services to release or obtain any information acquired in the course of my evaluation and treatment to my insurance company, my attorney, or referring physician.

I assign and request payment of all medical benefits/payments from my insurance and/or attorney to Specialized Therapy Services for medical services rendered. I also understand that I am financially responsible for any charges not covered by insurance or denied by any judgments or settlements. Furthermore; should my account become delinquent and a credit card is on file, I authorize Specialized Therapy Services to use what is one file for payment.

Patient Signature: _____ Date: _____

Please print your name: _____