

Welcome to Colorado Athletic Conditioning Clinic

Thank you for selecting our healthcare team! In partnership with the medical community, our mission is to provide our patients and the community with the knowledge, personal service and skills needed to return to a fulfilling life through our advanced expertise in physical rehabilitation. If you have any questions or need help, please ask. We will be happy to assist you.

OFFICE USE ONLY	Patient Information
	Last Name: _____ First Name: _____ MI: _____ Date: _____ Legal Guardian/Responsible Party: _____ Current Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell: _____ SS# _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Student <input type="checkbox"/> Single <input type="checkbox"/> Married Date of Birth: _____ (mm/dd/yyyy) Email Address: _____ Permanent Address: _____ City: _____ State: _____ Zip: _____ Employer: _____ Occupation: _____ Employer Address: _____
Provider:	

ICD-9 Code	General Information
	Referring Doctor: _____ Work Comp Doctor: _____ Family Doctor: _____ Description of Problem: _____ On Going Problem/injury? _____ Accident? Work _____ Auto _____ Other _____ If Work Comp: Claim Number: _____ Date of Onset: _____ Adjuster's Name: _____ Phone Number: _____ Insurance Company Name: _____ Address: _____ If Auto: Type of Accident: _____ Date of Accident: _____ Has Fault Been Established? Yours: _____ Other: _____ If Accident is your fault, complete "Your Auto Insurance" Section. If not, fill out "At Fault Driver's Insurance" Section. At Fault Driver's Insurance Company: _____ Adjuster: _____ Phone Number: _____ Policy Holder's Name: _____ Claim Number: _____ Your Auto Insurance Company: _____ Adjuster: _____ Phone Number: _____ Claim Number: _____ Do you have an attorney? _____ May we have permission to speak to him/her regarding your treatment and payment at Colorado Athletic Conditioning Clinic? Yes _____ No _____ If Yes, Name: _____ Phone Number: _____ Medical/Health Insurance (Please complete if MVA): Insurance Company: _____ PPO _____ HMO _____ Other _____ Policy/ID #: _____ Phone Number: _____ Secondary Insurance(If Applicable): _____ Policy/ID #: _____ Phone Number: _____

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Assignment of Benefits: I hereby assign payment directly to Colorado Athletic Conditioning Clinic, who represents this clinic to Payer Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance, I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Signature: _____ **Date:** _____