Patient Information Form

Full Name_____ Date of Birth _____

Address_____

City_____ State_____ Zipcode_____

Billing Address (if different)_____

Home Phone (_____)_____ Cell Phone (_____)_____

Emergency Contact_____ Phone (_____)_____

Social Security #_____

Insurance Information

Insurance Carrier_____ Relationship to Insured_____

Subscriber ID_____ Group ID_____

Physician Information

Primary Care Physician_____ Phone (_____)_____

Specialist_____ Phone (_____)_____

Choice of Payment

Rental equipment requires Credit/Debit card to be securely stored on file

( ) Check ( ) VISA ( ) Master Card ( ) American Express

During today's visit, RT Medical will charge your credit/debit card for your co-pay or order total if your deductible has not been met. We will send a claim to your insurance carrier. Your insurance carrier will send us payment for its portion of your treatment and notify us of any remaining financial responsibility that you may have. If there is a remaining amount above the initial charge during this visit the remaining balance will be charged to your credit/debit card at that time.

I hereby authorize RT Medical to securely maintain my credit/debit card information on file to cover my financial responsibility for services rendered today and futes dates of service. _____ (initial)

Customer Signature Date