NEW REHABILITATION SERVICES

Carla J. Hedtke, BS, M.S., B.C.T.P.M
5765 KZ Lane – Oconto Falls, WI 54154
920-373-5002 (Fax) 920-846-3267

Please PRINT

Patient Information Date: ___________________

Patient First Name_____________________MI_______Last Name____________________
Address____
City______________________________________ State____________ Zip______________
Phone: H_______________________Wk_____________________Cell_______________
Best time to call____
E mail____
Date Of Birth____________________________Age_________________________________
Social Security #____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married
Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_______________

Occupation____
Employer Name______________________________ Employer Phone__________________
Contact Name_______________________Position_______________________________
Is patient's condition related to: ☐ Work ☐ Auto ☐ Other ☐ Illness
Date of Injury____________________ Completed Injury Report: ☐ Yes ☐ No

Primary Health Care Provider

Name____Title__________________________
Specialty_____________________Phone________________________FAX_______________
Clinic___________________________Address___________________________________
City_____________________________ State____________Zip______________________

Insured (if other than patient)

First Name___________________________MI_________Last Name_____________________
Address____
City______________________________________ State____________ Zip________________
Phone: H_______________________Wk____________________ Cell___________________
Date of Birth________________SS#_____________________ ☐ Male ☐ Female

Employer Name__________________________ Employer Phone______________________
Contact Name____________________________Position_____________________________

Continue to page 2.

Attorney (if retained)

Name____Title___________________________
Contact_________________________Phone____________________FAX_________________
Firm____________________________________Address_________________________________
City___________________________________State__________________Zip______________

Primary Insurance Coverage- Copy of card accepted.

Insurance Carrier____
Phone_____________________________________Provider #____________________________
Insured Name____
ID#____Group#_______________________________
Date of Birth______________________________SS#____________________________________
Relationship to patient____
Billing Address____
City_______________________________________State______________Zip_________________

Secondary Insurance Coverage- Copy of card accepted.

Insurance Carrier____
Phone______________________________________Provider#____________________________
Insured Name____
ID#______________________________________Group__________________________________
Date Of Birth__________________________________SS#_______________________________
Relationship to Patient____
Billing Address____
City____State______________Zip______________

Assignment of Benefits

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my healthcare providers for the purpose of processing my claims.

Continue to page 3

Financial Responsibility

It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes a partial payment, I am responsible for the balance.

Referred by: *(Please check)* ☐ **Healthcare Professional** ☐ **Personal**

Name____Title______________________________
Clinic________________________________Address____
City_______________________________________State_______________Zip__________________

SIGNATURE____DATE______________

Thank you, for choosing Trigger Point Myotherapy.

Notes: