ERA Physical Therapy

707 Lake Cook Rd Deerfield, IL 60022

(847)630-2541
(224)444-0372

Name (Last):_____ (First)_____(Middle):_____

Spouse's (Last):_____(First):_____(Middle):_____

Address:_____City:_____State:____Zip:_____

Day Phone: (____)_____Evening: (____)_____ Cell Phone: (____)_____

Date of Birth:____/____/_____ Male ◘ Female ◘ Email:_____

Primary Care Physician:_____ Phone: (____)_____

Insurance Information

Type of Coverage for Treatment: **PPO ◘ HMO ◘ Medicare ◘ Workers Comp ◘ Motor Vehicle Accident ◘ Personal Injury ◘**
Date of Injury:____/____/____

Medicare Patients only: I am under the care health agency: Yes No.

Primary Carrier:_____ Phone: (____)_____

Address: _____City:_____ State:___ Zip:_____

ID#:_____Group#:_____

Policy Holder:_____ Date of Birth:__/__/__relationship:___ _____

Secondary Carrier:_____ Phone: (____)_____

Address: _____City:_____ State:____ Zip:_____

ID#:_____Group#:_____

Policy Holder:_____ Date of Birth:__/__/__relationship:___ _____

Address (If Different):_____ City:_____ State:____ Zip:_____

Policy Holder's Employer: _____ Phone: (____)_____

Address:_____ City:_____ State:____ Zip:_____

W/C Liable Party's Carrier: _____ Phone: (____)_____

Address: _____City:_____ State:____ Zip:_____

Contact Person:_____ Claim #:_____

Attorney or Firm Name (If applicable):_____

Address: _____City:_____ State:____ Zip:_____

Contact Person:_____ Claim #:_____

Authorization and Assignment: I hereby authorize my insurance carrier to make payments directly to ERA Physical Therapy, INC. on my behalf. I herby acknowledge my financial responsibility for fees not paid by this assignment and agree to pay in addition to the principle amount owed. I agree to pay 25% of the unpaid balance as a collection fee if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and court costs arising out of any litigation concerning the collection of the account.

Signature:_____ Date:_____