

DUNBAR THERAPY CENTER

1313 Dunbar Avenue Dunbar WV 25064 Phone: 304-400-4896 Fax: 304-400-4897

Physical - Occupational - Speech Therapy

PATIENT INSURANCE INFORMATION

FILL OUT ONLY IF DIFFERENT FROM PATIENT

Name of Insured:		Relationship to Patient:		Date of Birth:
Address:	City:	State:	Zip code:	
Home Phone:	Other Phone:		Email address:	

Employer Information			
Employer name:		Employment status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp.	
Address:	City:	State:	Zip Code:
Phone:		Occupation:	

Policy Information (Office Use Only)					
Primary Insurance:		Policy Number:		Effective Date:	
Address:	City:	State	Zip Code	Phone Number:	
Visits allowed:		Copay: <input type="checkbox"/> Yes <input type="checkbox"/> No			
PT		Copay Amount: \$			
OT		Deductible: \$			
ST		Met: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Authorization Required:		Authorization Number:		Authorization Dates:	
PT: <input type="checkbox"/> Yes <input type="checkbox"/> No		PT		PT	
OT: <input type="checkbox"/> Yes <input type="checkbox"/> No		OT		OT	
ST: <input type="checkbox"/> Yes <input type="checkbox"/> No		ST		ST	

ADDITIONAL NOTES:

Secondary Insurance:		Policy Number:		Effective Date:
Address:	City:	State	Zip Code	Phone Number:

ADDITIONAL NOTES: