The ExerScience Center

24706 State Road 54
Lutz, Fl 33559
Phone: (813) 803-7070

Patient Information Sheet

Name: _____ **Date of Birth:** _____

Home Phone: _____ **Cell Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____ **SSN:** _____

Emergency Contact: _____ **Phone:** _____

Insurance Carrier: _____ **Phone Number:** _____

Member ID: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth(policy holder):** _____

Physician(first & last): _____ **Phone:** _____

Diagnosis: _____

Patient Information release Authorization and Assignment of Insurance Benefits

Please be aware that all medical information is confidential under certain state and federal laws. Such information is may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and/or your healthcare team.

I,_____, do hereby authorize The ExerScience Center, to acquire from and/or release to my healthcare team and /or my insurance company(s), any information required for the purposes of healthcare management and/or for processing all medical claims on my behalf. I understand that upon acceptance of treatment from The ExerScience Center, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize The ExerScience Center to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to The ExerScience Center. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to The ExerScience Center. I have read and completed this form and certify that all the above information is correct to the best of my knowledge.

_____ _____

Signature of Patient **Date**

_____ _____

Parent (if patient is a minor) **Date**