INSURANCE INFORMATION

Please check which clinic you will be attending therapy.
Please remember to bring your picture ID and insurance cards.

{ } Belvidere Physical Therapy- Belvidere, IL { } Marengo Physical Therapy- Marengo, IL
{ } McHenry County Physical Therapy- McHenry, IL { } Ogle County Physical Therapy- Byron, IL
{ } Poplar Grove Physical Therapy- Poplar Grove, IL { } Roscoe Physical Therapy- Roscoe, IL

Patient Information

Patient Name: _____ _____ _____
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

Insurance Information

PRIMARY Insurance Name: _____

Claim Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____) _____

GROUP #: _____ **POLICY #:** _____

Insured Name (if different than patient): _____ DOB: ___/___/___

Social Security # (if different than patient): _____ - _____ - _____ Gender: __ Male __ Female

Address (if different than patient): _____

City: _____State: _____ Zip: _____

SECONDARY Insurance Name: _____

Claim Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____) _____

GROUP #: _____ **POLICY #:** _____

Insured Name: _____ DOB: ___/___/___

Social Security # (if different than patient): _____ - _____ - _____ Gender: __ Male __ Female

Address (if different than patient): _____

City: _____State: _____ Zip: _____

THIRD Insurance Name & Address: _____

GROUP #: _____ **POLICY #:** _____

Office Use Only: _____ HIPPA consent on file _____ Assignment of benefits on file

---

Patient/ Guardian Signature: _____ Date: _____