



Physical Therapy
Occupational Therapy
Speech Pathology

88 E. Schoolhouse Rd. | Yorkville, IL. 60560 | 630.553.6888 (o) | 630.553.3737 (f)
www.SpeckmanRehab.com

Patient's Name: _____ Date of Birth: _____
 Parent's / Guardian's Names: _____
 Social Security: _____ Email: _____
 Address: _____ City/St/Zip: _____
 Home Phone: _____ Cell: _____
 Emergency Contact (Someone not attending appointments): _____
 Referring Physician: _____ Phone: _____
 Practice Name: _____ Town: _____
 Reason for visit: _____ Therapy needed: Physical Occupational &/or Speech
 Has the patient had an evaluation for this type of service in the last year: _____
 If yes - When and Where: _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ SSN of Policy Holder: _____
 Policy Holders Address: _____ DOB of Policy Holder: _____
 Insurance Company: _____
 Identification Number: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION

Policy Holder: _____ SSN of Policy Holder: _____
 Policy Holders Address: _____ DOB of Policy Holder: _____
 Insurance Company: _____
 Identification Number: _____ Group Number: _____

CAR ACCIDENT OR WORK RELATED INJURY

Incident: _____ Date of Injury: _____
 Insurance Company: _____ Claim Number: _____
 Adjuster's Name: _____ Phone: _____

****** PAYMENT IS DUE AT TIME OF SERVICE******

I understand and agree that regardless of insurance status, I am ultimately financially responsible for full payment for services rendered to me or my dependents in this office. I also understand that I am financially responsible for missed appointments if I do not call 24 hours prior to the appointment as outlined in the Missed Appointment Policy (separate document)

I hereby authorize Speckman Rehab Center to obtain or release all requested health information regarding care and treatment of myself or my dependents from/to insurance agencies, medical professional persons and attorneys with authorized release. I also authorize payment directly to the above named facility of the medical plan otherwise payable to me.

Signature _____ Date _____

I also authorize the release of above mentioned information to my secondary insurance company

Signature _____ Date _____