NEUROHOPE
www.neurohopewellness.org

NeuroHope of Indiana, Inc.
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Indianapolis, IN 46236
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Registration Form

Patient Information

Patient Name _____
Address _____
Phone _____ Email _____
Patient DOB _____ Patient SS # _____
Physician _____ Phone _____
Emergency Contact _____ Phone _____
Race *(check one)* ☐ Caucasian ☐ African American ☐ Asian ☐ Pacific Islander ☐ American Indiana ☐ Other
Ethnicity *(check one)* ☐ Non-Hispanic ☐ Hispanic

Accident Information

Injury _____ Date of Injury _____
Cause of Injury _____
_____
Diagnosis Codes _____

Physical Therapy

Date of Initial Evaluation _____ Time Scheduled _____
Previous Therapy (past year) _____
Diagnosis Codes _____
_____

Primary Insurance

Insurance Company _____ Phone _____
Policy Holder _____ Employer _____
Member ID # _____ Group # _____ Member SS # _____
Member DOB _____ Relationship to Patient _____
Authorization # _____ Date _____
Number of Days/Visits Approved _____ No Authorization Required ☐
Deductible _____ Met ☐ Co-insurance/Copay _____ Met ☐
Benefits/Comments _____
_____

Secondary Insurance

Insurance Company _____ Phone _____
Policy Holder _____ Employer _____
Member ID # _____ Group # _____ Member SS # _____
Member DOB _____ Relationship to Patient _____
Authorization # _____ Date _____
Number of Days/Visits Approved _____ No Authorization Required ☐
Benefits/Comments _____
_____