Competitive Edge

640 Brooker Creek Blvd. #425
Oldsmar, Fl 34688
Phone (813) 849-0150 Fax: (813)849-0151

Patient Information Sheet

Name: _____Date of Birth: _____

Home Phone:_____ Cell Phone:_____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____SSN:_____

Spouse/ Parent: _____Phone:_____

Emergency Contact: _____ Phone: _____

Insurance Company: _____ Phone Number:_____

Policy Number:_____ Group Number:_____

Policy Holder:_____ Date of Birth:_____

Physician: _____ Phone Number:_____

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 herby authorize Competitive Edge Performance, Inc., hereafter known as CEP, 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 CEP, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize CEP to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to CEP. 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 CEP. 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**