SELF REFERRAL FORM

Patient Information:

Name		**DOB**
Address		**SSN**
City	**Zip**	**Phone**
Primary Insurance		**Member No.**
Secondary Insurance		**Member No.**

Physician/NP/PA Information:

Name	**Phone**

Chronic Health Conditions:

O	**High Blood Pressure**	**O**	**Depression/Anxiety**
O	**Congestive Heart Failure**	**O**	**Obstructive Sleep Apnea**
O	**High Cholesterol**	**O**	**Low back pain**
O	**Obesity**	**O**	**Seizure disorder**
O	**Thyroid Disease**	**O**	**Stroke/TIA**
O	**Diabetes**	**O**	**Chronic Kidney Disease**
O	**Neuropathy**	**O**	**Blindness**
O	**COPD**	**O**	**Tremors**
O	**Dementia**	**O**	**Heart Attack**

Authorization:

I hereby authorize: 1) the release of medical information by my primary care physicians, hospitals, nursing facilitates and/or outpatient facilities to OT2GO for the purpose of obtaining authorization for services to be rendered or for the payment of insurance claims 2) authorize release of medical information between OT2GO, physicians, insurance company(s), hospitals, nursing facilities, and/or outpatient facilities that may require filing of an insurance claim or appeal a claim on my behalf. I also give authorization to my insurance company to pay OT2GO for services provided. I hereby authorize future contact for care from OT2GO, follow up, and continual treatment, regarding the services that have been provided. My plan of care allows for OT2GO to continue this contact, at any future time, while I receive services from OT2GO.

Signature	**Date**