LAFAYETTE PHYSICAL THERAPY, INC.

Patient Information

Legal Last Name		Legal First Name	MI	Sex	Preferred Name
Home Phone	Cell Phone	SSN	DOB		Marital Status
Address		City	State		Zip
Employer		Occupation	Work Phone		
Adjuster Name		**Adjuster Phone**	**Adjuster Fax**		
Emergency Contact Person*		Relation	Phone		*For emergencies and urgent info if we are unable to get ahold of you.
Have you received any outpatient rehabilitation therapy this year? ☐ Yes: _____ # visits ☐ No					
Automated Appt. Reminders: Please select a phone number &/or e-mail to receive appointment reminder notifications on: ☐ Home ☐ Cell ☐ Text ☐ No reminder ***For email reminder, please see email consent form**					

FOR OFFICE USE ONLY:
Our front desk will fill out this portion upon your

Insurance: The following benefits were quoted to us by your insurance company. This is not a guarantee of payment by your insurance. You are responsible for knowing your benefits.

MVA - _____

☒ Patient is eligible for benefits: Effective Date: _____ to _____

☒ Coverage is based on medical necessity ☒ Rx required

Benefits Information:

100% Insurance coverage until Med-Pay allowance have been exhausted *

Client/Guardian Initials: _____

***The total Med-Pay allowance can only be verified by the member. It is the member's responsibility to inform LPT of how much Med-Pay is available. In the event that Med-Pay amounts are exceeded, the member will be responsible for claims payment.**

If you know the total Med-Pay funds you have available, please list them here: $_____ Max $ per year and $_____remaining

(If you do not know this information please contact your adjuster and provide the information to Lafayette PT within 48 hours)

☒ Other: LPT can only verify whether or not you have an open MVA claim and that there is Med-Pay available. An open claim is not a guarantee of payment as claims are based on medical necessity.

I certify that the information provided is true and accurate. I authorize Lafayette Physical Therapy, Inc (herein referred to as LPT) to bill my insurance carrier and instruct my insurer to pay any benefits directly to LPT. I understand that any charges not covered by my insurance will be my responsibility. I agree to pay LPT any amount due after my insurance company has paid or made a decision on my claims. **Should my insurance pay me directly, I agree to forward the payment to LPT.** I have read and understand the above information. A photocopy of this agreement shall be as valid as the original.

_____ _____ Office Use: _____

Client/Guarantor Signature Date Interviewer Initials