



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			
Insurance Subscriber Name		Ins. Subscriber Employer		DOB		Relation	
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? <input type="checkbox"/> Yes: _____ # visits <input type="checkbox"/> No							
Automated Appt. Reminders: Please select a phone number &/or e-mail to receive appointment reminder notifications on: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Text <input type="checkbox"/> No reminder *For email reminder, please see email consent form							
Do you currently have any open claims? i.e. worker's comp, motor vehicle accident, injury, etc. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Explain: _____							

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.

Medicare Patient is eligible for benefits: Effective Date: _____ to _____ Month to month coverage
 Coverage is based on medical necessity Rx required Requires Prior Authorization

Physical Therapy Benefits Information:

\$2080.00 Therapy threshold per calendar year; \$ _____ remaining, **combined with physical & speech therapy**

\$198.00 Total deductible, \$ _____ met toward your deductible. **Any deductible amounts owed will be billed to you***

Medicare pays 80%, _____ pays _____ % after a \$ _____ deductible (\$ _____ met) *

Other Secondary Insurance Info: _____

Client/Guardian Initials: _____

***Lafayette Physical Therapy will bill both your primary and secondary insurance prior to billing you. Any balances remaining after your primary and secondary insurance have paid will be billed to you. Payment is due upon the receipt of a billing statement.**

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.

Client/Guarantor Signature _____ Date _____

Office Use: _____
Interviewer Initials

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