Rev. 2019

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? ☐ 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**

Do you currently have any open claims? i.e. worker's comp, motor vehicle accident, injury, etc. ☐ No ☐ Yes
☐ Explain: _____

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

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.

_____ ☐ Patient is eligible for benefits: Effective Date: _____ to _____ ☐ Month to month Plan

☐ Out of network insurance plan ☐ Coverage is based on medical necessity ☐ Rx required ☐ Requires Prior Authorization

Physical Therapy Benefits Information:

$_____ Total deductible, $_____ met toward deductible, we will collect $_____ per visit toward your deductible*

Insurance pays _____ %, patient responsibility is _____ co-pay / co-insurance. We will collect $_____ **per visit***

☐ Your initial visit includes both evaluation & treatment which can have a higher share of cost. We will collect $_____for the initial visit*

$_____ Out of pocket, $_____ out of pocket met. Once met, insurance will cover at 100%

_____ Max visits per year, _____ visits used, _____ remaining, combined with: _____

_____ Other/Secondary Info: _____

Client/Guardian Initials: _____

***Patient financial responsibility may be MORE than the amount collected at each visit to go toward your deductible or co-insurance. The cost of each visit is based on the services you receive on a given day. You will receive a bill for any remaining balances once your insurance processes your claims.**

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