LaMarco Physical Therapy
Patient Information

Date:_____ Referring MD _____Diagnosis:_____
Therapist _____ Initial Eval Date/Time _____
Have you ever been a patient of LaMarco Physical Therapy? ☐Yes ☐No Referred by:_____
-Before Today, have you had PT, OT or Speech therapy this calendar year? ☐Yes ☐No
Insurance will not pay for Physical Therapy and Chiropractic treatment on the same day.

Last Name _____ First name_____ DOB_____ Sex M / F
Street Address_____ City_____
State_____ Zip_____ Email_____
Cell Phone_____ Home Phone_____
Emergency contact _____ Phone_____
Employer _____ Work Phone_____

Please fill out for minors or if patient has a legal guardian

Legal Guardian Name_____ DOB_____
Relationship to Patient_____ Phone_____

Insurance Information

Primary_____ ID#_____-_____
Subscriber_____ Relationship _____DOB_____
Secondary if applicable_____ ID#_____
Subscriber_____ Relationship _____DOB_____
Copay/Deductible (Office only) _____
COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED.

I authorize release of any information to process my insurance claim, assign payments directly to my provider, and acknowledge that I am financially responsible for any unpaid balance on my account for professional services rendered. I assign all medical/surgical benefits to LaMarco Physical Therapy.

Payment of Medicare Benefits: Medicare reimburses for Physical Therapy services up to $2150. I request that payment of authorized Medicare/Secondary benefits be made to LaMarco Physical Therapy, for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

CANCELLATION POLICY: You must cancel your appointment within 24 hours of your scheduled appointment time, or you will incur a $25 charge. Your insurance company is not responsible for this fee.

I have read all the above information. I certify this information is true and correct to the best of my knowledge.

Signature_____ **Date**_____

All patients requiring the use of electric stimulation as part of therapy will be given the option to use a generic set of pads OR may purchase their own to be kept separate and used exclusively for them.

- ☐ I elect to use generic pads
- ☐ I choose to purchase my own pads for $10

Office use only:
Workers Comp/No Fault Carrier_____ Date of Injury/Accident_____
**Social Security # (All) _____ Claim #_____ State of Accident_____
Carrier Address_____ Visits Approved_____ Exp Date_____
Case Manager/Phone # _____ Employer (All WC) _____