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:_____________

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_________________________________

Please be aware that insurance will not pay for Physical Therapy and Chiropractic treatment on the same day.

Insurance Information

Have you had PT, OT or Speech therapy this calendar year? ☐Yes ☐No

Primary________________________________ ID#____
Social Security ___________________________________
Subscriber_______________________________ Relationship ____________________DOB_______________
Secondary if applicable_________________________ ID#_______________________________________
Subscriber_______________________________ Relationship ____________________DOB_______________

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*