

# Wel come

Thank you for selecting our healthcare team at Layne Physical Therapy, LLC. We will strive to provide you with excellence in service. We are dedicated to giving each Patient a personal service that they can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask- we will be happy to assist you. **Please inform us of any changes in your information or insurance!!**

## *Patient Information*

Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_

Your Current address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone H \_\_\_\_\_ W \_\_\_\_\_ cell \_\_\_\_\_

Social Security \_\_\_\_\_ Male Female Student Single

Married

Date of Birth: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ Drivers License

\_\_\_\_\_

Permanent Address \_\_\_\_\_

City \_\_\_\_\_ State, \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## General information

Date of onset of problem \_\_\_\_\_ Surgery date \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Family Doctor \_\_\_\_\_

Description of Problem \_\_\_\_\_

Ongoing problem or new? \_\_\_\_\_ Work Accident \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_

**If Work Comp:** Claim Number \_\_\_\_\_

Adjusters Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

**If Auto:** Type of Accident \_\_\_\_\_ Date of Accident \_\_\_\_\_

Has Fault Been Established? Your's \_\_\_\_\_ Other \_\_\_\_\_

If Accident is your fault, fill out your Auto insurance Section. If not, fill out AT-Fault Driver's insurance Section.

**At Fault Driver's Insurance Company** \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

**Your Auto Insurance Company** \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone Number \_\_\_\_\_

Claim Number \_\_\_\_\_

Do you have an Attorney? \_\_\_\_\_ May we have permission to speak with him/her regarding your treatment and payment at Layne Physical Therapy? Yes. \_\_\_\_\_ No \_\_\_\_\_

If Yes, Name \_\_\_\_\_ Phone Number \_\_\_\_\_ **Your**

## **Medical/ Health Insurance (please fill out even if you have filled out the above)**

Who is responsible for the account?

Name last \_\_\_\_\_ first \_\_\_\_\_ relationship to patient? \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Insurance company \_\_\_\_\_

PPO \_\_\_\_\_ HMO \_\_\_\_\_ Other \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Phone Number \_\_\_\_\_

Secondary Insurance company (if applicable) \_\_\_\_\_

PPO \_\_\_\_\_ HMO \_\_\_\_\_ Other \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**We will need a copy of your insurance cards. Please give us new copies if insurance changes.**

**Medical Information:**

Please list your current medications: (for example Advil taken for knee pain)

- 1. \_\_\_\_\_ taken for \_\_\_\_\_
- 2. \_\_\_\_\_ taken for \_\_\_\_\_
- 3. \_\_\_\_\_ taken for \_\_\_\_\_
- 4. \_\_\_\_\_ taken for \_\_\_\_\_
- 5. \_\_\_\_\_ taken for \_\_\_\_\_

Please list your current medical problems and any past relevant injuries or surgeries with dates: (for example heart disease, diabetes, fractures, HIV+)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Missed Appointments:**

Unless cancelled at least 24 hours in advance, our policy is to charge **\$30.00** for missed appointments per each half-hour scheduled. We have a 24 hour answering service. We may have patients waiting for appointments on a cancellation list. Your courtesy of a phone call allows us to schedule them. This charge is not covered by or billed to your insurance. If due, please pay it at the front desk before your next appointment. Your signature indicates that you understand our policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Supplies and equipment:**

I agree to pay for physical therapy **supplies** in full on the date of service. I understand that Layne Physical Therapy **does not accept insurance as a durable medical goods provider** with my insurance company to provide supplies, orthotics, equipment or any durable medical good. I understand that I will only be reimbursed the amount of money paid to Layne Physical Therapy by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Release of Information**

I **do/do not** (please circle one) authorize \_\_\_\_\_ (physicians name) to release any of my medical records, x-rays, or reports to Layne Physical Therapy for the purpose of obtaining medical information pertaining to my treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Assignment of Benefits:**

I hereby assign payment directly to Layne Physical Therapy, who represents this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information in writing to Layne Physical Therapy as soon as any changes occur in my insurance coverage or address.

Signature \_\_\_\_\_ Date \_\_\_\_\_