LeMoine Physical Therapy

Commercial Insurance - Patient & Payor Information Form (Please Print)

1) Patient Information – All Patient or Patient's Legal Representative, please complete all sections

Patient Name (Last, First, MI) –Full Legal Name or as on Insurance Card	Sex	Marital Status	Date of Birth	Social Security No.

Street Address	City, State, Zip	Mobile Phone
Employer	Employer Address	Home Phone
Email Address		Work Phone

2) Guarantor / Guardian Information (Responsible Party)

Guarantor / Guardian Name	Sex	Relation to Patient	DOB	Social Security No.

Street Address	City, State, Zip	Home/Mobile Phone
Guarantor / Guardian Employer	Employer Address	Work Phone

3) Other Information

Referring Doctor (Name, Location)		
Family Doctor (Name, Location)		
Emergency Contact	Cell Phone	Work Phone

4) If Filing Insurance: Check A or B

A. ☐ Patient is the Insured (Do not complete the rest of #2)

B. ☐ Insured is ☐ Spouse ☐ Parent

Patient Name (Last, First, MI)	Sex	Date of Birth	Mobile Phone

Street Address	City, State, Zip	Home Phone

5) Why did you choose LeMoine Physical Therapy? (Select one answer only)?

☐ Doctor	☐ I'm a Returning Patient	☐ Google Maps/Reviews
☐ My Insurance	☐ Social Media (Instagram, Twitter)	☐ Facebook
☐ Friend or family	☐ Other:	☐ Yelp!
☐ Walked by/in	_____	☐ General Online Search

6) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name:	Employer Phone #:
Street Address	City, State and Zip Code

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7) Credit Card Payment Authorization

I hereby authorize LeMoine Physical Therapy to charge my credit card for services rendered until this authorization is revoked by me. It is my responsibility to notify LeMoine Physical Therapy any changes regarding this credit card authorization.

Name on Card	Signature / Date

Credit Card Type	Credit Card Number	
☐ Visa ☐ MasterCard ☐ Discover ☐ American Express		
Expiration Date	Security Code	Billing Zip Code

8) Payor Insurance Information

☐ Check if you have given your insurance(s) to Front Desk **(proceed to 8)**

Primary Insurance Company:

Ins. Co. Name:_____ Insured's Name:_____ Ins. Phone:_____

Patient ID #: _____ Group. #: _____ Policy/Plan #: _____

Secondary Insurance Company (If YES, please complete)

Ins. Co. Name:_____ Insured's Name:_____ Ins. Phone:_____

Patient ID #: _____ Group. #: _____ Policy/Plan #: _____

9) Payment Authorization: (Initials required for all 3 statements)

Assignment of Benefits

I Authorize that the payment of my insurance benefits be made directly to LeMoine Physical Therapy for all services delivered; if I am paid directly I will promptly pay LeMoine Physical Therapy all monies paid to me.

_____ Initials

Patient assigns to LEMOINE PHYSICAL THERAPY any and all benefits payable by Patient's insurance or health care plans. Including medical payments coverage, as a result of charges incurred by Patient for services rendered by LEMOINE PHYSICAL THERAPY. Patient also assigns to LEMOINE PHYSICAL THERAPY any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by LEMOINE PHYSICAL THERAPY. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.

Guarantee of Payment

_____ Initials

I understand that all payments designated as 'the patient's responsibility' such as co-insurance and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.

Certification of Information

_____ Initials

I certify that the information I have provided LeMoine Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

10)I attest, to the best of my knowledge, the above information is accurate and true

Signature/ Date: _____

_____ _____

Patient or Legal Representative's Signature **Today's Date**

LeMoine Physical Therapy

CONSENT FOR CARE AND TREATMENT
I the undersigned, having legal authority to do so, do hereby agree and give consent for LeMoine Physical Therapy to furnish medical care and treatment to as considered necessary and proper in diagnosing or treating my/his/her condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION
I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled, to LeMoine Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to LeMoine Physical Therapy, Inc. within five (5) days of receipt of such payment.

I hereby authorize the benefit assignment / release of all information necessary, including Medical Records, to secure payment. _____**Initials**

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL LEMOINE PHYSICAL THERAPY SERVICES:
I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, LeMoine Physical Therapy Inc. will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for LeMoine Physical Therapy Inc. to take action to secure payment of an outstanding balance owed.

SCHEDULING AND CANCELLATION POLICY
LeMoine Physical Therapy urges you to keep every appointment, as consistent treatment will expedite your recovery. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Saturday and Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $30.00 charge for each occurrence. Arrival more than 30 minutes after the time of your scheduled appointment may be considered a failed appointment.

ACKNOWLEDGEMENT OF OFFER OF NOTICE OF PRIVACY PRACTICES _____Initials

NO GUARANTEES: I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy rendered at LeMoine Physical Therapy, Inc.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my therapist the nature and purpose of Physical Therapy treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Physical Therapy treatments offered or recommended to me by my Doctor and/or Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care.

Patient Print Name: _____ Date _____

Patient's Signature: _____ Date _____

Guardian/ Responsible Party: _____ Date _____

LeMoine Physical Therapy

Health History (Please Print)

Patient Name (Last, First, MI)	Age:	Height:	Weight:	Today's Date

Do you have a pacemaker? Yes No	Do you smoke? Yes No	Are you latex sensitive? Yes No

ALLERGIES:

MEDICATIONS (include pills, injections and/or skin patches):

Have you ever taken steroid medications for any medical conditions? **Yes** **No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes** **No**

SURGERIES, INJURIES, AND HOSPITALIZATIONS:

Diagnostic Tests (for example: x-ray, MRI, CT Scan, Bone Scan, blood tests):

Treatment received so far for this injury, pain, or problem:

Occupation, including activities that comprise your work day:

Are you on a work restriction from your doctor? **Yes** **No** If yes, explain:

Leisure activities, including exercise:

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? Yes No

Have you RECENTLY experienced any of the following (check all that apply)?

□ Fatigue	□ Numbness or tingling	□ Constipation
□ Fever/chills/sweats	□ Muscle weakness	□ Diarrhea
□ Nausea/vomiting	□ Dizziness/lightheadedness	□ Shortness of breath
□ Weight loss/gain	□ Heartburn/indigestion	□ Fainting
□ Difficulty maintaining balance while walking	□ Difficulty swallowing	□ Cough
□ Falls	□ Changes in bowel or bladder function	□ Headaches

Have YOU EVER been diagnosed with any of the following conditions (check all that apply)?

□ AIDS / HIV	□ Depression	□ Thyroid problems
□ Cancer	□ Lung problems	□ Diabetes
□ Heart problems	□ Tuberculosis	□ Osteoporosis
□ Chest pain/angina	□ Asthma	□ Multiple sclerosis
□ High blood pressure	□ Rheumatoid arthritis	□ Epilepsy / Seizures
□ Circulation problems	□ Other arthritic condition	□ Eye problem/infection
□ Blood clots	□ Bladder/urinary tract infection	□ Ulcers
□ Stroke	□ Kidney problem/infection	□ Liver problems
□ Anemia	□ Sexually transmitted disease	□ Hepatitis
□ Bone or joint infection	□ Pelvic inflammatory disease	□ Pneumonia
□ Chemical dependency (i.e., alcoholism, recreational drugs)		

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

□ Cancer	□ Diabetes	□ Tuberculosis
□ Heart problems	□ Stroke	□ Thyroid problems
□ High blood pressure	□ Depression	□ Blood clots

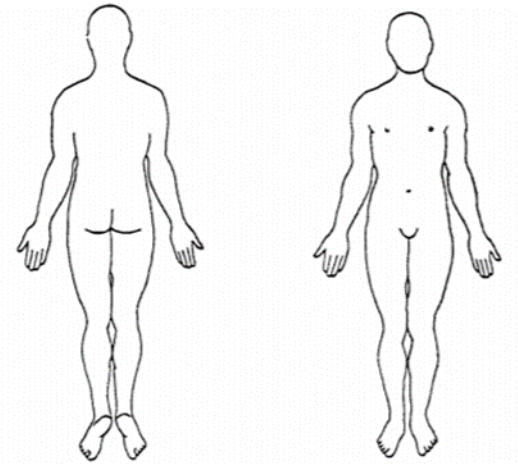
Approximately what date did your symptoms start (include surgery date if applicable)?

What do you think caused your symptoms, injury and/or pain?

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Can you identify positions or activities that make your symptoms worse?

1)

2)

3)

Symptom relieving Factors: Can you identify positions or activities that make your symptoms better?

1)

2)

3)

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "emergency room pain" please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Have you ever had this injury before: ❑ Yes ❑ No When_____ Treatment rec'd_____