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**

ASSIGNMENT, LIEN, RELEASE, LETTER OF PROTECTION AND POWER OF ATTORNEY

I, _____ ("Patient'), hereby authorize, grant and recognize the establishment of *a* lien in favor of LEMOINE PHYSICAL THERAPY for all treatments, services, and surgeries performed and to be performed for Patient. This Lien and Security Agreement may include, but is not limited to, fees and costs originating from evaluation, consuls! on, rehabilitation, diagnostic testing, facility usage, and other services rendered to Patient. Patient therefore agrees as follows:

ACCORDINGLY, IT IS HEREBY AGREED:

1. Patient hereby authorizes LEMOINE PHYSICAL THERAPY to furnish a full report and records regarding ease history, elimination, diagnosis, treatment prognosis, x-rays, laboratory reports and the results of all tests of any type or character such persons as LEMOINE PHYSICAL THERAPY deems appropriate
2. 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.
3. Patient fully understands that Patient Is directly and fully responsible to LEMOINE PHYSICAL THERAPY for all bills submitted for services rendered and that this agreement Is made solely or additional protection and consideration for awaiting payment. Patients further understand that Such payment is not contingent on any settlement. claims, judgments. or verdicts which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by LEMOINE PHYSICAL THERAPY, Patient agrees to be responsible for any such outstanding balance, including Interest at 9% per annum, reasonable attorney's fees and costs.
4. Patient fully understands that the lien and assignment given to LEMOINE PHYSICAL THERAPY herein Is irrevocable.
5. By executing this agreement. Patient hereby instructs and directs any attorney-representing Patient to honor the above lien assignment and make payment under the lien and assignment directly to LEMOINE PHYSICAL THERAPY Patient directs that attorney be bound by this lien and treat it Irrevocably, as an assignment due to LEMOINE PHYSICAL THERAPY. LEMOINE PHYSICAL THERAPY Is relying upon lien, assignment and directive to any attorney, and as a result of such reliance. LEMOINE PHYSICAL THERAPY is providing care and treatment for which this lien assignment and directive provide security for payment. Moreover, Patient agrees that it Is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.
6. Patient hereby directs all Insurers and other persons possibly responsible for Patient's health care costs to make all payments for healthcare services rendered by LEMOINE PHYSICAL THERAPY directly to LEMOINE PHYSICAL THERAPY.
7. Patient agrees that in the event Patient receives **any check, draft *or* other payment subject to this agreement**, Patient agrees to act as fiduciary agent for LEMOINE PHYSICAL THERAPY and **will Immediately** deliver said check, draft, or payment to LEMOINE PHYSICAL THERAPY to be applied to Patient's debt for services rendered.
8. Patient hereby appoints_____as Patient's true and lawful attorney, irrevocable, and with full power of substitution for Patient and in Patient's name to ask. demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third-party claims relating to services rendered to Patient by LEMOINE PHYSICAL THERAPY. LEMOINE PHYSICAL THERAPY Is not obligated or compelled to exercise such powers but may do so in LEMOINE PHYSICAL THERAPY sole discretion. Patient agrees to fully cooperate with LEMOINE PHYSICAL THERAPY in collecting said amounts.
9. LEMOINE PHYSICAL THERAPY agrees to submit a copy of this agreement with the Initial claim form(s) which LEMOINE PHYSICAL THERAPY submits to third-party payer(s) of the assignment and other agreements contained herein. At the time each claim Is submitted, *a* copy of the claim will be stored for safekeeping in Patient's file and may be requested by Patient, to be mailed to any designated address.
10. Patient hereby authorizes LEMOINE PHYSICAL THERAPY to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions Patient acknowledges that he/she received, and may in the future receive, valuable services from LEMOINE PHYSICAL THERAPY for which LEMOINE PHYSICAL THERAPY is owed compensation. Patient authorizes LEMOINE PHYSICAL THERAPY to make reasonable inquiries regarding the status of his/her personal Injury claim. Including contacting Patient's attorney. Patient agrees to instruct his/her attorney to fully cooperate with LEMOINE PHYSICAL THERAPY inquiries. Patient also agrees to provide to LEMOINE PHYSICAL THERAPY, current contact information for his/her attorney, including name, telephone, fax. mailing address, and email address.
11. A copy of these documents shall be as binding as the document bearing the original signatures.

Whereas, I have a right or cause of action out of personal injury, to wit:

I, _____, hereby authorize LeMoine Physical Therapy to furnish upon request to my attorney:

Any and all medical records, or reports of examination, diagnosis, treatment, or prognosis but not necessarily limited to those items as set forth herein. In addition to an itemized statement of accounts for services rendered therefore or in connection therewith, which my attorney may, from time to time, request in connection with my injuries describe above and sustained by me on the _____ day of _____, 20_____.

I,_____, hereby irrevocably authorize and direct my attorney to pay all charges for medical services rendered or any other responsible and customary charges incurred by my attorney as submitted by LeMoine Physical Therapy (LEMOINE PHYSICAL THERAPY] in connection with said injury Said payment or payments are to be made from any money or monies received by my attorney whether by judgment, decree, or settlement of this case, prior to disbursement to me and payment of the amount as herein directed shall be the same as If pa-d by me. This authorization to pay the aforementioned practice, LeMoine Physical Therapy, shall constitute and be deemed as assignment of so much of my recovery I receive, it is agreed that **nothing herein relieves me of the primary responsibility and obligation of paying my doctor** or LeMoine Physical Therapy for services rendered, and **I shall at all times remain personally liable** for such indebtedness unless by payment disbursed by my attorney. I accept the above assignment:

Date: _____ Patient Signature: _____

As the attorney of recorded for the above-named, I hereby agree to observe the terms of this agreement, and to withhold from any award in this case sums as are required for the adequate protection of LeMoine Physical Therapy.

Date: _____ Attorney Signature: _____

Patient Printed Name:	DOB:	SSN:	**LEMOINE PHYSICAL THERAPY**	
Patient Home Address	City/Zip:	Phone:	Rossville Professional Center 1232 Race Road Ste 203 Rosedale, MD 21237	6615 Reisterstown Rd Ste 300 Baltimore, MD 21215
Attorney's Name	Attorney Phone:	Date of Injury: State:		

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 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 release of all information necessary, including Medical Records, to secure payment.

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 $40.00 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 guarantees 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

Rossville Professional Center * 1232 Race Road Suite 203, Rosedale, MD 21237

info@lemoinephysicaltherapy.com * Office: 410-918-0080 * Fax: 410-918-0050

Cancellation/ Late Arrival Policy

In order to maintain available appointment times for all of our patients, LeMoine Physical Therapy is reminding all patients that there is a cancellation/ late arrival policy in place, and it must be adhered to. Appointments canceled without a business day notice, "No Call/ No Show", or arrival of 30 or more minutes late without notifying the office in advance, are subject to a $40 fee per each visit that violates this policy. Late appointments will be rescheduled to a new date and time, and a fee will be charged for the missed visit. The patient will be billed directly, and the balance must be paid in full prior to returning to any future appointments. Two consecutive last minute canceled or "No Call/ No Show" appointments will result in discharge from therapy. LeMoine Physical Therapy reserves the right to waive this policy under certain circumstances.

_____ _____

Patient Signature **Date**

_____ _____

Staff Signature **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

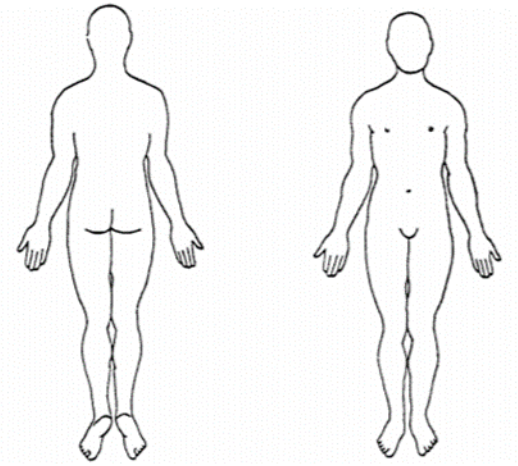
Approximately what date did your symptoms start (include surgery date if applicable)?

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_____