Thank you for selecting **Lifespan Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services, PLLC**! We will strive to provide you with the best possible physical therapy. To help us meet all your physical therapy needs, please fill out this form *completely*. If you have any questions or need assistance, please ask us—we will be happy to help.

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home phone: _____ Cell phone: _____

SS #: _____ Sex: □male □female

Primary Care Physician: _____ NPI #: _____ Phone #: _____

Referring Physician: _____ NPI #: _____ Phone #: _____

Reason for Visit: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency contact: _____ Relationship: _____ Phone #: _____

INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE: _____

Subscriber ID#: _____ Group #: _____

Person responsible for account: _____ Relationship: □self □spouse □parent

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____ SS#: _____

SECONDARY HEALTH INSURANCE: _____

Subscriber ID#: _____ Group #: _____

Person responsible for account: _____ Relationship: □self □spouse □parent

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____ SS#: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the therapist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance. I understand that if I have no insurance, I am personally liable for this entire bill. WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS, DEDUCTIBLES, CO-INSURANCE, CO-PAYS AND OTHER ITEMS NOT COVERED BY INSURANCE OR UNBILLABLE ITEMS BE PAID AT THE CONCLUSION OF EACH VISIT.

In the event my account is assigned to a collection agency or to an attorney to enforce collection, I agree to pay all collection costs and fees incurred. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my record to any collection agency or attorney. I hereby assign medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Lifespan Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I understand that the healthcare providers, under managed care contract obligations, must report patients who refused to pay co-payments, deductibles, co-insurance at the time of service, or who repeatedly do not show for scheduled appointments. I know that if I am reported for such things I could possibly lose my healthcare benefits and/or be discharged from the practice. *I also understand that 24 hours notice is required to cancel an appointment and the Lifespan PT, OT, and SLP Services, PLLC reserves the right to charge me $35 for any cancelled or missed appointment without a 24-hour notice. If I do not show without a 24 hour notice for a new patient appointment with a therapist I acknowledge I may be unable to reschedule for any further appointments with the Lifespan PT, OT & SLP Services, PLLC. Three or more missed/cancelled follow-up appointments will likely result in termination of care.*

PATIENT SIGNATURE _____ **DATE** _____