WELCOME TO OUR PRACTICE **LEMOINE PHYSICAL THERAPY**

PATIENT INFORMATION

Date _____ Soc. Sec.# _____ Birthdate _____

Name _____ Home Phone _____

Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Sex □ M □ F □ Minor □ Single □ Married □ Long Tern Partner □ Divorce □ Windowed □ Separated

Employer_____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone_____

REFERRING PHYSICIAN INFORMATION

_____ UPIN_____

Physician Last Name First Name Initial NPI# _____

Address _____ Telephone _____

City _____ State _____ Zip _____ Fax _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last Name First Name Initial

Relationship to Patient_____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Responsible Party Employed By _____Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____ Adjuster Name _____

Insurance Company Address _____

Subscriber I.D. # _____ Group# _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Person Responsible for Account _____

Last Name First Name Initial

Relationship to Patient_____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Responsible Party Employed By _____Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____ Adjuster Name _____

Insurance Company Address _____

Subscriber I.D. # _____ Group# _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to LEMOINE PHYSICAL THERAPY for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility of the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection services fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charge at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old.

Signature of Responsible Party _____ Date _____