LAKE RIDGE PHYSICAL THERAPY, LLC

☐ Lake Ridge clinic
Tel 703-730-6969

☐ Fusion clinic
Tel 571-659-2612

PATIENT INFORMATION *(please print clearly)*

Are you a: ☐ New Patient ☐ Returning Patient ☐ Existing Patient – Information has changed during treatment

Name: _____ Social Security #: _____
Last *First* *MI*

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ ☑ Primary Contact Preference ☐

Home: _____ ☐

Work: _____ ☐

Email: _____ ☐

Referring Doctor: _____

Have you had prior physical therapy this year?
Yes **No**

If Yes, explain:

EMERGENCY CONTACT

Contact: _____ Relationship: _____

Phone #: _____ Alternate Phone #: _____

INSURANCE

Primary Insurance: _____

Subscriber: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____

Subscriber: _____ Relationship: _____ DOB: _____

Tertiary Insurance: _____

Subscriber: _____ Relationship: _____ DOB: _____

MOTOR VEHICLE ACCIDENT *(if applicable)*

Date of Injury: _____ What state did the accident occur in? _____

WORKER'S COMPENSATION *(if applicable)*

Worker's Comp Carrier: _____ Date of Injury: _____

Claim #: _____ Contact / Ph#: _____

Claim Address: _____

Employer: _____

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CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I understand that the previous page's information is necessary to provide me with rehabilitation treatment in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Lake Ridge Physical Therapy, LLC (D.B.A. Fusion Physical Therapy) provide treatment and care as prescribed by my physician and/or recommended by my therapist.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance carrier in order to determine benefits to which I may be entitled.

PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Lake Ridge Physical Therapy, LLC (D.B.A. Fusion Physical Therapy) to apply for benefits on my behalf for services rendered by them, and request payment from my insurance carrier be made directly to Lake Ridge Physical Therapy, LLC (D.B.A. Fusion Physical Therapy).

Either my insurance carrier or I may revoke this authorization at any time in writing. I permit a copy of this authorization to be used in place of the original.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The services you have elected to participate in imply a financial responsibility on your part. You are responsible for payment of your deductible and co-payment / co-insurance as determined by your contract with your insurance carrier. All co-payments must be paid at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved time period, you will be responsible for your account balance in full.

DELINQUENT ACCOUNTS: Should your account become delinquent, you will be responsible for all collection costs which is 33 1/3 of the principal amounts.

RETURNED CHECK FEE: I, the undersigned, agree to pay a fee of $30.00 for any check returned by my financial institution regardless of reason.

REFERRALS / AUTHORIZATIONS: Some managed care plans require written authorization forms from your primary care physician for each visit to a specialist. It is the patient's responsibility to make sure that Lake Ridge Physical Therapy, LLC (D.B.A. Fusion Physical Therapy) has a valid authorization form before each visit. These forms cannot be issued retroactively. Failure to obtain authorization may drastically reduce your benefits/coverage with your insurance carrier.

APPOINTMENTS: All appointments should be scheduled in advance and 24 hour notice is required for cancellations. Patients who are more than fifteen (15) minutes late for a scheduled visit may not be seen depending on the discretion of the therapist. The patient may be rescheduled for a future visit if not seen. There is a $30 fee charged for all NO SHOW / NO CALL visits as well as SAME DAY CANCELLATIONS.

I certify that I have read the above policies (i.e., Consent to Treatment and Authorization to Release Information; Patient Authorization for Direct Payment; and Statement of Financial Responsibility) and herby give consent to each.

I understand that I may request a copy of this agreement at any time.

Signature: _____ Date: _____

Printed Name: _____