PATIENT INFORMATION

Name (First)_____ (Last)_____(MI)_____
(If minor, name of responsible parent) _____(Parent's_DOB)_____
Date of Birth_____ Email Address _____
Address_____City_____State_____ZIP_____
Phone(home)_____Phone(work)_____Phone(cell)_____
Employer_____Address_____City_____ State_____ZIP_____
Phone_____Occupation (if retired, former profession) _____
Referring MD_____ Primary MD_____
Next appointment date with referring MD?_____/_____/_____ Injury Type(circle): Work Auto Home Other
Emergency Contact_____Phone_____
Whom may we thank for your referral?_____

INSURANCE INFORMATION

Name of Insurance Co._____
Policy Holder's Name (or self) _____ or Relationship to patient_____ DOB_____
Cert or ID#_____Group #_____
Secondary Insurance_____
Policy Holder's Name_____Relationship to Patient_____
Cert or ID#_____Group#_____

Please read, and then sign:

I request that all authorized benefits be paid to Jason A. Campopiano, PT, PLLC for any services or treatments provided to me by my physical therapist or provider. I do authorize the release of my medical information to the extent required to determine benefits payable for services rendered to me by my physical therapist or provider, to be released to my insurance company or its agents.

I do understand that all co-pays or uninsured payments are due at the time services are provided. I also understand that I may be responsible for any balance due after insurance payment is received. I choose to receive the physical therapy services provided to me by my physical therapist, and if my insurance company denies payment for visits they deem to be not medically necessary, I will pay for my visit(s). Additionally, I understand that there shall be a charge of $25 for any check returned to Local Motion Physical Therapy from the bank.

I do understand that I must call to cancel an appointment 24 Hours in advance, and I will make every effort to do so.

I do understand that there is a fee of $50 for any evaluation appointment or $25 for any follow-up appointment for which I do not give a 24 Hour cancellation notice.

If I miss three appointments scheduled for me without calling 24 hours in advance, my therapist reserves the right to cancel all of my other scheduled appointments without notice.

Signature_____Date_____