Loudoun Physical Therapy

Multiple Therapies & Caring Professionals
Restoring Your Good Health

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE, LAST)					HOME PHONE
HOME ADDRESS / CITY / STATE / ZIP					CELL PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	AGE	MARITAL STATUS	EMAIL
EMPLOYER				OCCUPATION	WORK PHONE
REFERRING PHYSICIAN (NAME, ADDRESS, PHONE)					

EMERGENCY CONTACT INFORMATION

NAME	PHONE	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS (CITY, STATE, ZIP)			PHONE
SUBSCRIBER'S NAME	DOB	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT
GROUP NUMBER		ID OR POLICY NUMBER	EFFECTIVE DATE

CO-PAY/CO-INSURANCE PAYMENTS REQUIRED AT TIME OF SERVICE

Credit Card – VISA , MASTERCARD, DISCOVER – Please circle one

CREDIT CARD NUMBER	EXPIRATION DATE	CARD HOLDER'S ZIP CODE
SIGNATURE	DATE	

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I consent to treatment necessary for the care of the above named client.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Loudoun Physical Therapy, Inc and their professional staff, and authorize transfer of all unpaid amounts to my Visa/MasterCard, Discover after 120 days from the date of service.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

______________________________ ______________________________

Signature of Patient/Parent/Guardian Date