

Patient Information (No-Fault)

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthdate: ____/____/____ Home Phone: _____ Work Phone: _____ Cell Phone: _____
Gender (circle): M / F Social Security #: _____ (Use signing parent's # if patient is minor under 19 yrs)
Email Address: _____ Can we email appointment reminders & information? Yes / No
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

No-Fault Insurance Information

Insurance Company Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone#: _____
Date of Accident: ____/____/____ Policy #: _____ Policy Holder's Name: _____
Case Manager: _____ Phone#: _____ Fax#: _____

Secondary Insurance Information: (private insurance if claim is denied)

Insurance Company Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone#: _____
ID#: _____ Group#: _____ Name of Insured Person: _____
Relation: _____ Birthdate: ____/____/____ Insured Employer: _____
Employer Address: _____

I give my permission to Lake Erie Physical Therapy, LLC to Release information to my insurance company. I authorize payment directly to Lake EriePhysical Therapy, LLC for treatment I receive.

Signature: _____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

I agree I am primarily liable for all charges for services rendered by Lake Erie Physical Therapy, LLC and agree to pay all amounts not paid by my insurance carrier(s) for any reason. If I am claiming coverage under No-Fault laws, I understand I am fully liable if such coverage is subsequently denied. I agree to supply private insurance information in anticipation of such a denial. If I am claiming coverage through an HMO (such as IHA, Com Blue or Univera), I understand I am responsible for obtaining a valid referral prior to treatment if required and that treatment without such a referral will cause me to be personally liable for today's charged as well as future charges. I understand in the event amounts are not paid when due, I agree to pay all reasonable attorney's fees and collection costs you may incur to collect such past due amounts. If referred to collection, a fee of 33.33% of your outstanding balance over \$100 will be added to your account. For amounts less than \$100, 40% of the balance will be added to your account. If a second statement is required, a \$5.00 billing fee will be added to your account.

Signature: _____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

I have been advised of Lake Erie Physical Therapy's **Notice of Privacy Practices Regarding Patient Health Information**. You may request a copy of this at any time.

Signature: _____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

No-Fault Insurance

You must be covered under No-Fault insurance if you were injured in a motor vehicle accident. We will, as a courtesy, bill your no-fault carrier. However, if they do not pay, you will be responsible for the charges. If you have a secondary insurance on which you wish to rely, we must be given that information at the time of your **first** visit. HMO companies often require approvals and have benefits with limited visits. There is no guarantee your private insurance will cover your no-fault charges. You should also be aware that if you fail to pursue a valid No-Fault claim, your personal insurance will probably not cover our charges.

If you are also under Chiropractic care or receiving Massage Therapy for this injury, no-fault may not cover charges if treatment is given on the same day as Physical Therapy.

Signature: _____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

Cancellation/No-Show Policy

We request that you call as soon as possible if you are unable to make a scheduled appointment. We understand that there are many legitimate and unforeseeable reasons for being unable to attend a scheduled visit. Taking that into consideration, we will allow a total of 3 cancellations or no-shows during your physical therapy care before charging \$25 for each future cancellation or no-show.

Signature: _____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)