ROBERT LOUIE, PT
Access Physical Therapy

ADMISSION INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt# _____ □ Male □ Female

City: _____ State: _____ Zip: _____ Marital Status: _____

SS# _____ Date of Birth: ___/___/___

Home Phone: ( )_____

Work Phone: ( )_____

Cell Phone: ( )_____

Is there information regarding your health insurance or billing information we need to know? Please talk with the receptionist. Questions regarding coverage? Call our Patient Accounts Department at (661) 288-0022

Emergency Contact: _____ TEL#: _____ Relationship: _____

Billing/ Statement Information: Should we send your billing statement to another address?

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Primary Source of Payment: □ Health Plan □ Medicare □ Worker's Compensation □ Cash / Credit Card

Health plan co-payment or co-insurance amount: $ _____

Primary Care Physician: _____ Phone: ( )_____

Employer: _____ Phone: ( )_____

Health plan / Insurance: _____ Group #: _____ Subscriber #: _____

Secondary / additional Insurance: _____

A copy of your health plan card is required. Please have your card ready for the receptionist
A referral authorization may also be required.

Release and Assignment of Benefits

To my insurance carriers:

I authorize the release of any medical information necessary to process my insurance claim(s).

I authorize and request payment of medical (health) plan benefits directly to my physicians.

I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

I agree that a photocopy of this form may be used in lieu of the original.

Consent for Treatment

I authorize treatment as ordered and prescribed by my physician for (circle one) physical therapy, occupational therapy, and / or speech therapy. I have been informed of the potential risks and benefits of the prescribed procedures and hereby consent to treatment.

Financial Responsibility

I am responsible for any non-covered services, co-payments etc, and will make payments at each visit unless prior payment arrangements have been made.

We require 24 hour advance notice on any cancellations of scheduled appointments. Our therapists are compensated for their time even when a patient is a no-show or cancels unexpectedly. **All same day cancellations or no shows will be assessed a $25.00 fee which will be collected at your next visit or billed to you. _____(Patient Initials)**

If I am seeking treatment for work related injury or personal injury accident, and fail to complete treatment as ordered by my physician, or I fail to complete the legal process, I am responsible for payment of services.

Signature: _____ Date: _____