RICHARD L. STONEKING, PT
Lic. No. 40QA00221200

333 North Main Street
Lambertville, NJ 08530
609-397-9390
609-397-2586 fax

1230 Parkway Avenue
West Trenton, NJ 08628
609-883-7528
609-883-5947 fax

stonekingpt.com

PATIENT INFORMATION

Patient Name ___________________________________Age___________ Sex____________________________

Address ____

City_________________________ State____________________Zip_____________________________________

Date of Birth____________Marital Status_________ E-Mail____

May we send periodic informational e-mails to you? (Y)_____(N)_____

Home Phone__________________________________ Cell____

Employer_________________________Phone____________________Occupation_______________________

Address____ S.S.#___________________________________

Spouse/Guardian Name_______________________________ Phone# _________________________________

Employer____ Address________________________________

How did you hear about us?____________________________ Physician ______________________________

MEDICAL INFORMATION

Are you under the care of a physician for <u>any other</u> medical needs? __________yes__________no

If Yes, please list____

Are you taking any medication for any needs? ________yes_______no

If Yes, list____

Any other medical information we should be aware of?____

Person to contact in an emergency____

Phone#______________________________Relationship____

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INSURANCE COVERAGE INFORMATION

Are you presently receiving home care services (therapy, nursing, home health aide)? ____ Yes ____No

Have you recently received home care services (therapy, nursing, home health aide)? _____Yes ____No

If yes, discharge date:_________________________ Name of Agency:____________________________

Consent to Treatment: I consent to rehabilitation and related services at Stoneking Physical Therapy. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Initial______________

Authorization of Payment: I hereby assign all benefits directly to Stoneking Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. I understand that if my account is sent to collection, additional charges of up to 35% of billed charges will be added to my account for collection. Additionally, I authorize this healthcare provider to appeal on my behalf any adverse benefit determinations rendered by the payer or UR agent.

Initial______________

As a courtesy to you, our staff will verify with your insurer the physical therapy coverage limitations including deductible, co-pay, precertification and referral requirements, etc.

This is not a guarantee that verification obtained by telephone communication is 100% accurate. For that reason we encourage all patients to verify their own benefits as an added measure of safety.

Initial______________

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INSURANCE INFORMATION

Primary Insurance_________________________ Insured's Name___________________________

Address_________________________________ I.D.#__________________Group#___________

Secondary Insurance ______________________ Insured's Name___________________________

Address_________________________________ I.D.#__________________Group#___________

Insured's Date of Birth_____________________

WORKERS COMPENSATION CLAIMS

Our policy for filing workers compensation claims is to bill your insurance carrier or employer. The account should be paid in full by either the employer or the workers compensation insurance carrier. In the event your claim is denied by either the insurance carrier or employer, you will then be held responsible for the balance due.

MOTOR VEHICLE INSURANCE POLICY

Insurance carriers pay 80% of the first $5000 of medical expenses. This occurs after your chosen deductible (between $250.00 to $2,500.00) has been met. After the $5,000.00 threshold expenses are paid at 100%. For this reason, we ask that you furnish us with your private health insurance information as well as your automobile insurance for any unpaid portion of the bill.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature

____

Date

____

Witness Signature

____