TOTAL HEALTH
PHYSICAL THERAPY

Patient Information

Welcome! Thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be kept strictly confidential. (Please print clearly)

Patient Name _____

Street Address _____

City _____ **State**_____ **Zip/Postal Code**_____

Date of Birth_____ *(M/D/YR)* **(Circle)** Male / Female

Marital Status: (circle) Single Married Divorced Separated Widowed

If Child, Parent/ Guardian's Name_____

Contact Information

Please check or fill in only the acceptable methods that Total Health may use to contact you.

Total Health can contact me by phone: YES NO

Home Phone #

- ☐ You may only leave name and number when you call.
- ☐ You may leave a detailed message
- ☐ Preferred contact

Cell Phone #

- ☐ You may only leave name and number when you call.
- ☐ You may leave a detailed message
- ☐ Preferred contact
- ☐ You may text me
- ☐ I prefer text

Work Phone #

- ☐ You may only leave name and number when you call.
- ☐ You may leave a detailed message
- ☐ Preferred contact

Email address:

- ☐ Appointment reminders and statement information only
- ☐ Regarding my condition as necessary to inform me about my condition.
- ☐ Preferred contact

In Case of emergency, please provide us with the name of the nearest relative not residing with you:

Name_____ **Phone**_____
Relationship_____

Insurance Carrier

Request for Total Health Physical Therapy to file claims on your behalf: (circle) Yes No

Do you have an Rx? Yes No

(Rx is required for Medicare patients. Non Medicare Virginia patients only need Rx if they would like to file an insurance claim.)

Please check if one of the following applies: ____ **Worker's Compensation** ____**Insurance**

Insurance Carrier_____

Primary Insured Name_____

Primary Insured Date of Birth_____**Gender** _____

ID Number_____

Group Number_____

Medicare/ Medicaid Policy Number _____

Secondary Insurance_____

Secondary ID Number _____

Secondary Group Number_____

Employer _____

Occupation_____

Address_____

Phone_____

Referring Physician_____

Address _____

Phone _____

I understand that payment is expected on the day of each treatment, with the exception of Worker's Compensation insurance coverage. I am responsible for all charges, regardless of insurance coverage. I understand that Total Health Physical Therapy is not a Medicaid or Medicare Provider. I understand that Total Health Physical Therapy is an out-of-network provider and expects prompt payment of all bills when services are rendered.

Patient/ Guardian Signature_____ **Date**_____

We at Total Health PT are happy to electronically submit claims on your behalf as a courtesy, however you as the patient are responsible for ensuring that the insurance company properly processes your claims. We are unable to guarantee that your insurance will reimburse you. We will also be happy to provide you with a detailed invoice for you to submit to your insurance company for reimbursement. Please notify our office of any changes to your insurance by email at admin@totalhealthptdc.com. All changes must be submitted to Total Health PT via email and please allow 2 weeks for the changes to be processed.

Patient/ Guardian Signature_____ **Date**_____

Please Note: **All patients seen in our Virginia office must have a prescription from a physician covering the dates of treatment. Insurance will **NOT** reimburse patients for visits that are not covered by a prescription.

Patient/ Guardian Signature_____ **Date**_____