Edelman Spine & Orthopaedic Physical Therapy
Patient & Payer Information Form

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (____) _____-_____ (____) _____-_____ (____) _____-_____ We will text schedule reminders unless otherwise notified.
Home Work Cell

Birthdate: ____/____/____ **S.S. #** _____-____-____ **Gender:** _____ **Marital Status:** S M D W O

Email: _____ We will send out mass emails unless otherwise notified.

(2) Emergency Contact Information

Emergency Contact Name: _____ **Relationship:** _____ **Phone #:** _____

(3) Condition to be treated in Physical Therapy: _____

Date condition began? Date: ____/____/____
Is it related to an accident? No Yes If Yes: work / auto / other Date of Accident: _____
Do you have an Attorney? No Yes If Yes: Name: _____ Phone#: _____

Did this condition result in surgery? No Yes If Yes: Date of Surgery ____/____/____

Have you had previous treatment for this condition? No Yes
If Yes: Physical Therapy / Chiropractic / Other Where/When? _____

(4) Patient's Doctor: Please list Referring or Primary Care physician.

_____ (___) ____-_____
Doctor's Name: Last First Initial MD, DO, DDS, Other **Office Phone:**

(5) If Filing Insurance and Insured Party is other than patient:

Insured is ___**Spouse** ___**Parent** **Date of Birth:** _____ **Gender:** _____

Name: Last First Initial Sr./Jr.

Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____ Social Security #: _____
Home Mobile Work

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 2

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(6) Employer's Information (Please complete if the insured person's employer is the source of benefits)

Employer's Name: _____ **Employer's Phone #:** (___) _____-_____

Address: _____ _____
Street City State Zip Code

(7) Payer Information: ***MAY SKIP IF COPY OF INSURANCE CARDS PROVIDED TO OFFICE***

Primary Insurance Company:

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph #:** _____

Patient ID #: _____ **Group #:** _____ **Policy/Plan #:** _____

Secondary Insurance Company: (If YES, please complete) **Insured is:** _____Patient _____Spouse _____Parent

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph#:** _____

Patient ID #: _____ **Group #:** _____ **Policy/Plan #:** _____

Employer Name: _____ **Employer Phone #:** (___) _____-_____

Address: _____ _____
Street City State Zip Code

(9) Cancellation/Missed/No Show Appointment Policy

To assure quality care of all our patients, our schedule is arranged to both minimize wait time and maximize patient treatment time. When you miss an appointment, it prevents us from being able to help another patient. You may request a copy of this policy.

CANCELLATION POLICY: ***If you are unable to keep your appointment, please notify our office 24 hours prior to your scheduled time.*** Please be aware there is a ***$25.00 cancellation fee*** for appointments that are cancelled with <24 hours' notice. If >1 appointment is cancelled in the same week without 24 hours' notice the office reserves the right to cancel all future appointments. By initialing, you consent to our cancellation fee policy.

_____
Initials

NO SHOW POLICY: If you fail to appear for your scheduled appointment there is a ***$25.00 no show fee***. If you fail to appear for >1 appointment during the course of your treatment, the office reserves the right to cancel all all future appointments. By initialing, you consent to our no-show fee policy.

_____
Initials

It will be necessary for you to call the office to reschedule your appointments.
Insurance does not cover no show fees.

(10) Signature/ Date: _____
Patient or Legal Representative's Signature **Date**

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 2