Reactive PHYSICAL THERAPY

616 Wheatley Street Lexington, TX 78947
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Patient Demographic Sheet

Referred by: _____

Last Name: _____ **First Name:** _____

Mailing Address: _____ **Apt/Ste:** _____

City: _____ **State:** _____ **Zip:** _____

Gender: _____ **Marital Status:** _____ **E-mail:** _____

Employer: _____ **Occupation:** _____

Home Phone:_____ **Work:**_____ **Cell:** _____

Date of Birth: _____ **SSN:** _____ **Driver's License #:**_____

Emergency Contact:

1) Name _____ **Phone** _____ **Relationship** _____

2) Name _____ **Phone** _____ **Relationship** _____

Primary Insurance: _____ **Policy ID #:** _____

Group#: _____ **Policy Holder Name:** _____

Date of Birth: _____ **SSN:** _____ **Employer:** _____

Address (if different from Pt): _____

City _____ **State:** _____ **Zip:** _____ **Relationship to Pt:** _____

Are you covered by a secondary insurance? YES / NO

Secondary Insurance: _____ **Policy ID #:** _____

Group#: _____ **Policy Holder Name:** _____

Date of Birth: _____ **SSN:** _____ **Employer:** _____

Address (if different from Pt): _____

City _____ **State:** _____ **Zip:** _____ **Relationship to Pt:** _____

- Please try to provide at least 24 hours notice if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday.

- I hereby give authorization for payment of medical and/or auto insurance benefits and/or legal settlement payments to be made directly to Reactive Physical Therapy, and for any assisting therapist employed by or contracted with Reactive Physical Therapy.

- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance, provided I am notified in advance that any proposed service or therapy/treatment/procedure may not be covered by patient's insurance provider(s).

- I understand that all copay, coinsurance and deductible amounts are due and payable at the time of service, unless a payment arrangement has been made with the billing. If the explanation of benefits from the insurer(s) shows a remaining patient balance due, the patient will be billed accordingly.

- In the event of a default in payment, the prevailing party in any lawsuit or mediation will be entitled to recover reasonable attorney fees and actual costs of collection.

- I hereby authorize Reactive Physical Therapy to release any and all information necessary to secure payment of benefits to only those parties legally entitled to receive information for purposes of receiving payment of existing balances or for authorization for continuation of services as may be necessary or requested by the patient's insurer(s).

- I agree that a photocopy of this agreement shall be as valid as the original.

Thank you for you cooperation.

Patient (if minor – Parent or Legal Guardian) Signature: _____

Date: _____