EDGER THERAPY, P.A.

Private Physical Therapy Practice

7525 Greenway Center Drive, Suite 106
Greenbelt, Maryland 20770
301.474.1221
Fax 301.261.7851

Rosemary M. Edger, P.T.
President

Established 1982

DATE:_____

NAME:_____ **BIRTH DATE:**_____

ADDRESS:_____

HOME TELEPHONE:_____ **WORK PHONE:**_____

CELL PHONE:_____ **SOCIAL SECURITY NUMBER:**_____

EMPLOYER:_____ **OCCUPATION:**_____

SPOUSE:_____ **WORK NUMBER:**_____

WHOM MAY WE CONTACT IN AN EMERGENCY?_____ **TELEPHONE:**_____

INSURANCE INFORMATION:
PRIMARY CARRIER:_____ **I.D.NUMBER:**_____

ADDRESS:_____

NAME OF INSURED:_____ **BIRTH DATE:**_____

SECONDARY CARRIER:_____ **I.D.NUMBER:**_____

ADDRESS:_____

NAME OF INSURED:_____ **BIRTH DATE:**_____

IS TREATMENT HERE COVERED BY WORKMAN'S COMPENSATION?_____

IF YES, PLEASE PROVIDE CLAIM NUMBER, COMPANY NAME AND ADDRESS:

_____

CONTACT PERSON:_____ **TELEPHONE:**_____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU?_____ **IF YES, PLEASE PROVIDE THEIR NAME, ADDRESS AND TELEPHONE:**_____

_____

ATTENDING PHYSICIAN:_____

PERSONAL FITNESS ACTIVITIES:_____

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SIGNATURE CARD SYSTEM

PATIENT'S NAME:_____

INSURANCE CARRIER:_____ **I.D.NUMBER:**_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE TO EITHER MYSELF OR ON MY BEHALF TO EDGER THERAPY, P.A., FOR ANY SERVICES PROVIDED TO ME BY THAT OFFICE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER/ HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____

SIGNATURE **DATE**

_____ _____

WITNESS **DATE**

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OFFICE POLICY

WELCOME TO EDGER THERPY, P.A. PLEASE READ THE FOLLOWING INFORMATION REGARDING OUR OFFICE POLICIES SO AS TO BETTER INFORM YOU OF OUR SERVICES.

EDGER THERAPY, P.A., WILL BE BILLING YOUR INSURANCE CARRIER FOR SERVICES RENDERED. IF YOUR PRIMARY INSURANCE IS MEDICARE, THIS CARRIER WILL COVER 80 PERCENT OF THE BILL WITH THE REMAINING 20 PERCENT ADDRESSED BY YOUR SECONDARY INSURANCE. IF YOU DO NOT HAVE A SECONDARY INSURANCE, YOU WILL BE PERSONALLY RESPONSIBLE FOR THE REMAINING BALANCE.

IF YOUR PRIMARY INSURANCE IS A COMMERCIAL CARRIER, SUCH AS CAREFIRST OR UNITED HEALTHCARE, THERE IS TYPICALLY AN ASSOCIATED COPAYMENT DUE FROM THE PATIENT. YOUR PARTICULAR INSURANCE COMPANY WILL DICTATE WHAT THAT AMOUNT WILL BE. CO-PAYMENTS ARE DUE AT THE CONCLUSION OF EACH WEEK.

PATIENT AGREES TO EDGER THERAPY, P.A., SENDING COPIES OF THEIR MEDICAL RECORDS (OR INFORMATION FROM THEIR MEDICAL RECORDS) TO THEIR INSURANCE CARRIER OR OTHER SOURCES OF PAYMENT, WHICH MAY INCLUDE THEIR COMPLOYER WHEN THIS INFORMATION IS NECESSITATED TOWARD PAYMENT OF THEIR THERAPY BILLS.

PATIENT RELEASES AND FOREVER DISCHARGES EDGER THERAPY, P.A., ITS EMPLOYEES AND ITS AGENTS FROM ANY LIABILITY RESULTING FROM THE RELEASE OF THEIR MEDICAL RECORDS OR MEDICAL INFORMATION FOR PAYMENT PURPOSES.

CANCELLATIONS FOR SCHEDULED THERAPY APPOINTMENTS ARE TO BE MADE 24 HOURS IN ADVANCE. FAILURE TO PROVIDE SUFFICIENT NOTIFICATION OF AN APPOINTMENT CANCEL-LATION—EXCEPT IN CASES OF AN EMERGENCY—SHALL RESULT IN THIS OFFICE ASSESSING THE FULL OFFICE CHARGE FOR A MISSED APPOINTMENT.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS CONTRACT, AND HAVE HAD ALL MY QUESTIONS CONCERNING IT ANSWERED. I UNDERSTAND THIS CONTRACT AND I AGREE TO ITS TERMS.

PATIENT:_____ **DATE:**_____

WITNESS:_____ **DATE:**_____

IF THE PATIENT IS A MINOR, THE RESPONSIBLE PARTY MUST SIGN BELOW:

_____ **DATE:**_____

RELATIONSHIP TO PATIENT:_____