LeClair Therapy, Inc dba

Essex Physical Therapy (EPT), Georgia Physical Therapy (GPT), & On The Move Physical Therapy (OTM)

1 Marketplace Suite 33 and
21 Carmichael Street, Suite 101
Essex Jct., VT 05452

(GPT) 787 Ethan Allen Hwy
Georgia, VT 05468

Today's Date:_____

Patient Information

First Name:_____ Middle Initial: ___ Last Name:_____

Address:_____ City:_____ State:_____ ZIP:_____

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

Email Address: _____ Reminder Preference: Phone, Email or Text (circle one)

Date of Birth:_____ Biological Sex: M or **F Pronouns:_____**

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone Number:_____

How did you hear about us? (Please tell us if we can thank someone for your referral)

____ Patient Referral - Patient name: _____

____ Physician Referral - Physician Name: _____

____ Social Media ____ Internet Search ____ Yelp ____ Other : _____

Were you previously a patient of EPT, GPT or OTM? Y N

If yes, when?_____ Who provided your care? _____

Insurance Information

Primary Insurance Company:_____ ID/Member No._____

Group or Acct No._____ Copay Amount: _____

Insured's full name:_____ Relationship to Insured: _____

Insured's Employer: _____

Secondary Insurance Company:_____ ID/Member No._____

(form continues on back)

It is your responsibility to be aware of your personal insurance or Medicare requirements and benefits (including Physical Therapy) and to schedule accordingly. As a courtesy to you, we will bill your

insurance for you. Should your insurance deny payment for any reason, you will be required to pay for anything not covered by your insurance.

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Consent to Treatment and Assignment of Benefits

I hereby give my permission to EPT and/or GPT to examine me and administer treatment as is deemed necessary. I hereby assign all benefits directly to EPT and/or GPT. I understand fully in the event that my insurance does not pay for services I receive, I will be financially responsible for payment.

Signature: _____ Date: _____

Medical Release

I authorize EPT and/or GPT to release information from my medical records to insurance companies, their agents and the Health Care Financing Administration and its agents for the purpose of determining my medical benefits and for any benefits payable for related services.

I authorize EPT and/or GPT to release and receive medical records between Primary Care and/or Referral physicians and other medical specialists, including personal trainers, for the purpose of coordinating treatment.

Signature: _____ Date: _____

If patient is a minor or legally incapacitated, please obtain signature of a parent or guardian.

Privacy Practices Acknowledgement

I hereby acknowledge that I have read a copy of this practice's Notice of Privacy Practices.

Signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient: _____

Electronic Communication Acknowledgement and Consent

I hereby acknowledge that I have read a copy of this practice's Electronic Communication policy and authorize EPT and/or GPT to communicate with me electronically.

Signature: _____ Date: _____

Cancellation/No Show/Late Service Charge & Collection Agency Fees

Because we offer one-on-one patient care and reserve time specifically for you, we have a 24 hour cancellation policy. Failure to show, late arrival or appointments canceled or rescheduled within 24 business hours of your scheduled appointment will result in a **$50.00 charge billed to you**. If you arrive late, fail to show or cancel without proper notification for 2 or more appointments, we may consider not rescheduling you at our office.

In addition, if we are forced to utilize a collection agency to recover your debts owed to this office, we are authorized to pass the fees from the Collection Agency (30% surcharge plus interest) on to you and include them in the amount payable to our office.

Patient balances not paid within 30 days will be subject to a $25 Service Charge.

Thank you for your understanding. ____ **Patient initials**