TCA PHYSICAL THERAPY

Welcome to our Practice!

Patient Information Form

5435 HWY 1
Marksville, LA 71351

Today's Date : | **New Patient :** ☐ Yes ☐ **No**

Patient Information

Last Name/Suffix: | First Name: | Middle Initial:

Date of Birth: | Sex: ☐ M ☐ F | SSN:

Address: | City: | State: | Zip Code:

Home Phone: | Cell Phone: | Work Phone:

Emergency Contact Information

Relationship to Patient:

Contact Name: | Phone # | ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Insurance Information

Primary Insurance: _____ Deductible: _____ Subscriber Name: _____
Id# _____ Max Benefit: _____ Relationship: _____
Group # _____ CoPay: _____ Coinsurance: _____ Date of Birth: _____

Secondary Insurance: _____ Deductible: _____ Subscriber Name: _____
Id# _____ Max Benefit: _____ Relationship: _____
Group # _____ CoPay: _____ Coinsurance: _____ Date of Birth: _____

Tertiary Insurance: _____ Deductible: _____ Subscriber Name: _____
Id# _____ Max Benefit: _____ Relationship: _____
Group # _____ CoPay: _____ Coinsurance: _____ Date of Birth: _____

Additional Questions

Post Surgical: ☐ Yes ☐ No
Surgery Date (if applicable): _____

Surgery Description: _____

Have you any prior Therapy this year? ☐ ☐
(PT/OT/SP or Chiropractic)

Auto Related: ☐ Yes -State? _____ ☐ No
Work Related: ☐ Yes ☐ No

Adjuster name: _____

Phone #: _____

Diagnosis: _____
or What part of the body _____
are we treating: _____

Date of Injury: _____
or When did pain begin?: _____

MEDICARE ONLY- Additional Questions

Are you currently receiving Home Health Service? ☐ Yes ☐ No If yes, Name of Agency ? _____

Last Date of Service _____

Have you received PT, OT or Speech services since the first of the year? ☐ Yes ☐ No

Worker's Compensation ONLY- Additional Questions

Employer Name: _____ Patient Occupation: _____

Address: _____ City: _____ State: Zip:

Claim # _____ Additional info: _____

I certify that all the above information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, thereof, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided. If it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's case, I agree to pay Therapy Center of Avoyelles, LLC for services rendered. I authorize payment for these services be paid directly to Therapy Center of Avoyelles, LLC.

Signature: _____