BRIAN P. LAMBERT, P.T., L.L.C
1405 ROLKIN COURT, SUITE 102
CHARLOTTESVILLE, VA 22911

TEL: (434) 977-6700 **FAX: (434) 977-6779**

Patient Information:

Patient: ______________________ Date: ______________________

SS#: ______________________ Age: ______ Birth Date: ______________

Home Address: ______________________ Phone #: ______________________

______________________ Cell Phone: ______________________

Zip Code: ______________________ Email: ______________________

Gender M ___ F ___ Marital Status: Single Married Other:

Employed by: ______________________ Business Phone #: ______________________

Contact Information: (This information **must** be completed.)

Emergency Contact: ______________________ **Tel #:** ______________

Primary Care Physician: ______________________ **Tel #:** ______________

Referred by: ______________________ **Tel #:** ______________

PLEASE NOTE THAT ALL OF THE ABOVE INFORMATION IS STRICTLY CONFIDENTIAL. Your Email address will only be used by Brian P. Lambert, Physical Therapy for communication purposes, and will not be distributed in any other way.

Subscriber Insurance Information:

Insurance Company: ____

Subscriber: ______________________ Employer: ______________________

Relationship to Patient: ______________ Member ID #: ______________________

Subscriber's SS #: ______________________ Group #: ______________________

Subscriber's DOB: ______________________

Secondary Insurance Information: (Please complete only if applicable)

Insurance Company: ____

Subscriber: ______________________ Employer: ______________________

Subscriber's SS # ______________________ Member ID #: ______________________

Subscriber's DOB: ______________________

BRIAN P. LAMBERT, PT
PHYSICAL THERAPY

Name: ______________________________ Age: ___________Date:_______________

Height: _____________ Weight: ________ Hand Dominance: ____________________

Occupation: _________________________ Working (Yes/No): ___________________

Primary Complaint: Onset Date: ______________ Cause: _______________________

____

____

Secondary Complaint: Onset date: _____________ Cause: _____________________

____

Have you had previous Physical Therapy for this problem(s)? Yes: _____ No : _____

Dates: ____

What are your goals for treatment? ____

____

Medical History:

Heart disease: ____

Respiratory problems: ____

Cancer: ____

Bowel/Bladder problems: ____

Depression: ____

Do you have advance medical directives? Yes: ______ No: _______

Surgeries: ____

Medications: ____

____

____

BRIAN P. LAMBERT, P.T., L.L.C.
1405 ROLKIN COURT, SUITE 102
CHARLOTTESVILLE, VA 22911

(434) 977-6700

Date: ______________________________

Authorization for Treatment, Release of Information, Insurance Authorization and Assignment, and Financial Agreement

I, _______________________________________(patient of Brian P. Lambert, P.T. (BPL)) hereby authorize treatment. I authorize BPL, to furnish to insurance carriers any medical information, deemed necessary, in order to process this claim. I hereby assign BPL, all payments for medical services rendered to my dependents or myself. I understand that I am responsible for payment of any amount not covered by insurance and that billing the insurance company is a courtesy to me, and not an obligation of the Doctor's office. I acknowledge that insurance claims pending beyond (60) days are my responsibility and I agree that I will not delay payment and that I will pay the balance if a claim is pending more than 60 days. I understand that if I make a payment and BPL, thereafter receives payment from the insurance company, I will be reimbursed by BPL. I understand that if my account is still outstanding after ninety (90) days from the time that the services were rendered, my account may be referred to a collection agency or an attorney for collection. I agree to pay all costs of collection, including but not limited to thirty-five percent (35%) agency fees and to pay any necessary and reasonable attorney fee incurred in the collection of my account, whethe or not suit is filed.

Co-pays are due in full on the date of service. You are responsible for obtaining a referral if required by your insurance company. If this referral is not obtained, you are responsible for payment in full on the date of service.

The fee for a returned check is $35.00

There will be a $25.00 charge for any missed appointment without notice.

____
Patient Name (printed)

___________________________________ ______________________________
Patient Name (signature) **Date**

____
Witness