BRIAN P. LAMBERT, PT
1405 ROLKIN COURT, SUITE 102
CHARLOTTESVILLE, VA 22911
TEL: (434) 977-6700 FAX: (434) 977-6779

Patient Information

How did you hear of us: MD _____ Web Site _____

Friend or Former Patient: _____ Date: _____

Other: _____ Age: _____ Birthdate: _____

Patient: _____ Phone: _____

SS #: _____ Cell Phone: _____

Home Address: _____ E-Mail: _____

_____City _____ Marital Status: Single _____ Married _____Other _____

State _____ Zip Code_____ Employed By: _____

Gender: Male _____ Female _____ Bus Phone: _____

Contact Information (This information must be completed)

Emergency Contact: _____ Tel #: _____

Primary Care Physician: _____ Referring Physician: _____

PLEASE NOTE THAT ALL OF THE ABOVE INFORMATION IS STRICTLY CONFIDENTIAL. Your E-mail address will only be used by Brian P. Lambert, Physical Therapy for communicative 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. LAMPERT, PT
PATIENT HEALTH HISTORY

Name: _____ Age: _____ Date: _____

Height: _____ Weight: _____ Hand Dominance: _____

Occupation: _____ Working (Yes/No): _____

Primary Complaint: _____ Onset Date: _____

Cause: _____

Secondary Complaint: _____ Onset Date: _____

Cause: _____

For the last two weeks, please circle the number that describes your worst pain:

1	2	3	4	5	6	7	8	9	10
No pain		Slight		Moderate		Very much		Worst ever	

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

Dates: _____

What are your goals for treatment? _____

Medical History:

Heart disease: _____

Respiratory problems: _____

Cancer: _____

Bowel/Bladder problems: _____

Depression: _____

Surgeries: _____

Do you have advance medical directives? Yes: _____ No: _____

Current Medications/vitamins/herbs/supplements

	Name of medication	dose	frequency
1:			
2:			
3:			
4:			
5:			
6:			
7:			
8:			

(Revised 1/2015)

BRIAN P. LAMBERT, P.T., L.L.C.
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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 sixty (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 thirtyfive percent (35%) agency fees and to pay any necessary and reasonable attorney fee incurred in the collection of my account, whether 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