

**Essex Physical Therapy**  
**1 Marketplace Suite 33 Essex Jct, VT 05452**  
**Phone: 802-878-9572 Fax: 802-878-9592**

LeClair Therapy, Inc

Paquette Therapy, Inc

Today's Date: \_\_\_\_\_

**Patient Information**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Sex: M F

Social Security No. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_ Web \_\_\_\_ Yellow pages \_\_\_\_ Radio Ad \_\_\_\_ TV Ad \_\_\_\_ Other : \_\_\_\_\_

Were you previously a patient of Essex Physical Therapy? Y N

If yes, when? \_\_\_\_\_ Who provided your care? \_\_\_\_\_

**Insurance Information**

Primary Insurance Company: \_\_\_\_\_ Referral Needed? Y N

ID/Member No. \_\_\_\_\_ Group or Acct No. \_\_\_\_\_

Co-pay Amount (if applicable): \_\_\_\_\_ Deductible Amount (if applicable): \_\_\_\_\_

Maximum number of visits per year/diagnosis: \_\_\_\_\_ Other restrictions? \_\_\_\_\_

Insured's full name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

(Form continues on back!)

**Insurance Information (Continued)**

Secondary Insurance Company: \_\_\_\_\_ Referral Needed? Y N  
ID/Member No. \_\_\_\_\_ Group or Acct No. \_\_\_\_\_  
Co-pay Amount (if applicable): \_\_\_\_\_ Deductible Amount (if applicable): \_\_\_\_\_  
Maximum number of visits per year/diagnosis: \_\_\_\_\_ Other restrictions? \_\_\_\_\_  
Insured's full name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_

**Medicare patients: If your insurance is Medicare, please be aware that you must have a new referral from your doctor in your file at our office every 90 days. Failure to obtain a referral will result in a denial of payment from Medicare. Your therapist will work with you and your doctor to obtain additional referrals.**

**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.**

**Consent to Treatment and Assignment of Benefits**

I hereby give my permission to Essex Physical Therapy to examine me and administer treatment as is deemed necessary. I hereby assign all benefits directly to Essex Physical Therapy. I understand fully that 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 Essex Physical Therapy 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 Essex Physical Therapy 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.

**Because we offer one-on-one patient care and reserve time specifically for you, we have a 24 hour cancellation policy. Failure to show or cancel within 24 hours of your scheduled appointment will result in a \$35.00 charge billed to you. If you fail to show or cancel without proper notification for 2 or more appointments, we may consider not rescheduling you at our office. Thank you for your understanding. \_\_\_\_\_ Patient initials**