

EDGER THERAPY, P.A.

Private Physical Therapy Practice

7525 Greenway Center Drive, Suite 106
Greenbelt, Maryland 20770
301.474.1221
Fax 301.261.7851

Rosemary M. Edger, P.T.
President

Established 1982

DATE: _____

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

HOME TELEPHONE: _____ WORK PHONE: _____

CELL PHONE: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE: _____ WORK NUMBER: _____

WHOM MAY WE CONTACT
IN AN EMERGENCY? _____ TELEPHONE: _____

INSURANCE INFORMATION:
PRIMARY CARRIER: _____ I.D.NUMBER: _____

ADDRESS: _____

NAME OF INSURED: _____ BIRTH DATE: _____

SECONDARY CARRIER: _____ I.D.NUMBER: _____

ADDRESS: _____

NAME OF INSURED: _____ BIRTH DATE: _____

IS TREATMENT HERE COVERED BY WORKMAN'S COMPENSATION? _____

IF YES, PLEASE PROVIDE CLAIM NUMBER, COMPANY NAME AND ADDRESS:

CONTACT PERSON: _____ TELEPHONE: _____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU? _____ IF YES, PLEASE
PROVIDE THEIR NAME, ADDRESS AND TELEPHONE: _____

ATTENDING PHYSICIAN: _____

PERSONAL FITNESS ACTIVITIES: _____

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SIGNATURE CARD SYSTEM

PATIENT'S NAME: _____

INSURANCE CARRIER: _____ **I.D. NUMBER:** _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE TO EITHER MYSELF OR ON MY BEHALF TO EDGER THERAPY, P.A., FOR ANY SERVICES PROVIDED TO ME BY THAT OFFICE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER/ HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE

DATE

WITNESS

DATE

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OFFICE POLICY

WELCOME TO EDGER THERAPY, P.A. PLEASE READ THE FOLLOWING INFORMATION REGARDING OUR OFFICE POLICIES SO AS TO BETTER INFORM YOU OF OUR SERVICES.

EDGER THERAPY, P.A., WILL BE BILLING YOUR INSURANCE CARRIER FOR SERVICES RENDERED. HOWEVER, IF THE INSURANCE CARRIER DOES NOT REMIT IN 30 DAYS, THE PATIENT SHALL BE RESPONSIBLE FOR PAYMENT OF THE ENTIRE BILLED AMOUNT.

AT THE END OF EACH WEEK, PATIENT SHALL BE EXPECTED TO PAY THEIR CO-PAYMENT.

PATIENT AGREES TO EDGER THERAPY, P.A., SENDING COPIES OF THEIR MEDICAL RECORDS (OR INFORMATION FROM THEIR MEDICAL RECORDS) TO THEIR INSURANCE PROVIDER(S) OR OTHER SOURCES OF PAYMENT, WHICH MAY INCLUDE THEIR EMPLOYER. PATIENT IS TO UNDERSTAND THAT THIS INFORMATION WILL BE SENT WHEN IT IS NEEDED FOR PAYMENT OF THEIR THERAPY BILLS.

PATIENT RELEASES AND FOREVER DISCHARGES EDGER THERAPY, P.A., ITS EMPLOYEES AND ITS AGENTS FROM ANY LIABILITY RESULTING FROM THE RELEASE OF THEIR MEDICAL RECORDS OR MEDICAL INFORMATION FOR PAYMENT PURPOSES.

CANCELLATIONS FOR SCHEDULED THERAPY APPOINTMENTS ARE TO BE MADE 24 HOURS IN ADVANCE. FAILURE TO PROVIDE SUFFICIENT NOTIFICATION OF AN APPOINTMENT CANCELLATION—EXCEPT IN CASES OF AN EMERGENCY—SHALL RESULT IN THIS OFFICE ASSESSING THE FULL OFFICE CHARGE FOR A MISSED APPOINTMENT.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS CONTRACT, AND HAVE HAD ALL MY QUESTIONS CONCERNING IT ANSWERED. I UNDERSTAND THIS CONTRACT AND I AGREE TO ITS TERMS.

PATIENT: _____ **DATE:** _____
SIGNATURE

WITNESS: _____ **DATE:** _____
IF THE PATIENT IS A MINOR, THE RESPONSIBLE PARTY MUST SIGN BELOW:

RELATIONSHIP TO PATIENT: _____