Virginian Physical Therapy and staffing, LLC
20 Pidgeon Hill Dr. Suite 103
Sterling, VA 20165
Tel: (571) 313-0929
Fax: (571) 313-8270

PATIENT INFORMATION FORM

Please **PRINT** or ask to have this form filled out for you.

NAME: _____

HOME PHONE: (____) _____CELL PHONE: (____) _____ WORK PHONE: (____) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: M____ F____ BIRTH DATE: _____/_____/_____ SS#: _____-_____-_____

EMAIL: _____

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: (_____) _____ EXT #:_____

SPOUSE'S NAME: _____ SS#: _____

SPOUSE'S DATE OF BIRTH: _____ WORK PHONE: (_____) _____

SPOUSE'S EMPLOYER: _____

PRIMARY INSURANCE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #: _____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#:_____

SECONDARY INSURACE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #:_____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#: _____

REFFERRED BY: _____

REASON FOR REFFERRAL: _____

Virginian Physical Therapy and staffing, LLC

Assignment of Benefits Authorization, Responsibility for Payment and
Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I am financially responsible for the services provided to me by Virginian Physical Therapy and Staffing, LLC regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Virginian Physical Therapy and Staffing, LLC for any services provided to me by Virginian Physical Therapy and Staffing, LLC I authorize and direct any holder of medical information or documentation about me to release to the centers for Medicare and Medicaid Services and its carriers and agents, as well as to Virginian Physical Therapy and Staffing, LLC and its billing agents and any other payers or insurer any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Virginian Physical Therapy and Staffing, LLC now or in the future. I agree to immediately remit to Virginian Physical Therapy and Staffing, LLC any payments that I receive from any source for the services provided to me and I assign all rights to such payment to Virginian Physical Therapy and Staffing, LLC. The undersigned hereby guarantees payment to Virginian Physical Therapy and Staffing, LLC of all charges incurred, and if account is turned over for collection, he/she agrees to pay all cost of collection including collection fee equal to 33.3% of all sum due and payable. The undersigned here agrees to pay interest at a rate of 18% per annum (annual percentage rate) on all outstanding balances.

I, _____, also acknowledge that Virginian Physical Therapy and Staffing, LLC has notified me that the Notice of Privacy Practices is publicly displayed for my review in the office waiting room. For additional information and/or questions, I am aware that I may contact the privacy officer of Virginian Physical Therapy and Staffing, LLC.

_____ Date: _____
Patient Signature

_____ _____
Patient Representative's Signature Relationship to Patient