Erica D. Reid, OTR/L

PATIENT INFORMATION

Thank you for choosing Erica Reid, OTR/L. Please complete the following forms.
Please Print Clearly.

Patient's Name: ________________________________ Today's Date: ________/____________/___________

Address: ______________________________________ City: _________________St: _____ Zip: ___________

Home Phone: ___________________________________ Sex: M F Patient Date of Birth: _________________

Cell Phone: ____________________________________ Work Phone: __________________________________

Occupation: ___________________________________ Employer: _____________________________________

Referring Doctor: ________________________________ Email Address: _________________________________

Date of Injury: _________________________________ How did you hear about us? _____________________

Are you under 18 and/or a dependent on a guardian's insurance (circle one)? Yes No

If Yes, Guardian's Name: _______________________

Are you pregnant? _____________________________ If so, when is your due date? ____________________

Emergency Contact: ____________________________ Phone: _______________________________________

INSURANCE/BILLING INFORMATION

Please Provide Erica Reid, OTR/L with your primary and secondary health insurance information and a copy of your insurance card(s).

Name of Insured: _______________________________ Relationship to Patient: _________________________

Date of Birth of Provider: _______________________ Policy/ID #: ____________________________________

Primary Insurance Provider: ______________________ Services Contact #: _____________________________

Group #: ______________________________________ Policy/ID #: ____________________________________

Secondary Insurance Provider: ___________________ Services Contact #: _____________________________

Group #: ______________________________________

I certify the above information is true to the best of my knowledge. I will notify you of any changes in the above information.

Patient's Signature: _________________________ Date: _______/________/________

Erica D. Reid, OTR/L

Erica Reid, OTR/L POLICIES

Payment Policy: As a courtesy, Erica Reid, OTR/L has verified your insurance benefits and will bill your primary insurance carrier for you. Please remember that you are ultimately responsible for payment of all services rendered. Your portion of payment: private pay, co-payment, co-insurance and/or deductible payments are required at time of service for each visit.

I have read the above policy and I acknowledge that I am ultimately responsible for payment of all services rendered.

Signature: ______________________________________ Date: ____________/_____________/______________

(Patient or Legal Guardian)

CONSENT TO TREAT/AUTHORIZATION/ASSIGNMENT OF BENEFITS

I give consent to Erica Reid, OTR/L to provide Occupational Therapy services to me, my child or my legal ward.

Signature: ______________________________________ Date: ____________/_____________/______________

(Patient or Legal Guardian)

I hereby authorize Erica Reid, OTR/L to furnish to my insurance carrier(s) any and all requested information concerning my health. I also authorize my insurance carrier(s) to pay Erica Reid, OTR/L directly for any services rendered.

Signature: ______________________________________ Date: ____________/_____________/______________

(Patient or Legal Guardian)

CANCELLATION POLICY

Please give us 24 hours notice if you are unable to keep your scheduled appointment in order to avoid a $75 cancellation fee.

There are no exceptions to this $75 cancellation fee. Please note that we cannot bill your insurance for a missed/cancelled therapy appointment.

Signature: ______________________________________ Date:___________/_______________/______________

CREDIT CARD ON FILE

It is the policy of Erica Reid, OTR/L to require a credit card as security for payment of future charges, any remaining balances on your account and any cancellations fees incurred.

Cardholder name: ________________________________ Credit Card Type:_________________________________

Account Number: ________________________________ Expiration Date: ____/____/____ CSC (3-digit code)___

I hereby authorize Erica Reid, OTR/L to charge for the agreed amount for services rendered on the verification of benefits form and/or for any missed or cancelled appointments not cancelled within the designated time period. This information will be kept private and secured by Erica Reid, OTR/L.

Signature: ______________________________________ Date: __________/____________/_________________