

BRIAN P. LAMBERT, P.T., L.L.C.
198 SPOTNAP ROAD (SUITE C-5)
CHARLOTTSVILLE, VIRGINIA 22911

TEL: (434) 977-6700

FAX: (434) 977-6779

Patient Information:

Patient: _____ Date: _____
SS#: _____ Age: _____ Birth Date: _____
Home Address: _____ Phone #: _____
_____ Cell Phone: _____
Zip Code: _____ Email: _____
Gender M ___ F ___ Marital Status: Single Married Other:
Employed by: _____ Business Phone #: _____

Contact Information: (This information must be completed.)

Emergency Contact: _____ **Tel #:** _____
Primary Care Physician: _____ **Tel #:** _____
Referred by: _____ **Tel #:** _____

PLEASE NOTE THAT ALL OF THE ABOVE INFORMATION IS STRICTLY CONFIDENTIAL. Your Email address will only be used by Brian P. Lambert, Physical Therapy for communication 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. LAMBERT, PT

PHYSICAL THERAPY

Name: _____ Date: _____ Age: _____

Height: _____ Weight: _____ Hand Dominance: _____

Occupation: _____ Working (Yes/No): _____

Primary Complaint: _____

Onset Date: _____ Cause: _____

Please Complete if Applicable
(Pain Scale: 0=No pain, 10=Worst pain)

Morning: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

Sitting: 0 1 2 3 4 5 6 7 8 9 10

Afternoon: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

Walking: 0 1 2 3 4 5 6 7 8 9 10

Evening: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

Standing: 0 1 2 3 4 5 6 7 8 9 10

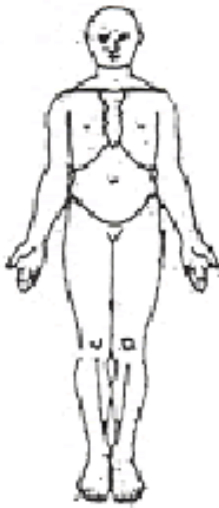
Night: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

Cough/sneeze: 0 1 2 3 4 5 6 7 8 9 10

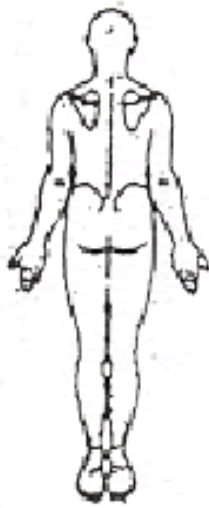
Bending: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

With medication: 0 1 2 3 4 5 6 7 8 9 10

Describe Areas: (///// = pain xxxxxx = numbness oooooo = burn ++++++ = pins and needles



Front



Back



Right Side



Left Side

Medical History:

Heart disease: _____

Respiratory Problems: _____

Cancer: _____

Bowel/Bladder Problems: _____

Depression: _____

Do you have advance medical directives? Yes No

Surgeries: _____

Medications: _____

Have you had previous Physical Therapy for the same problem? Yes No

Dates of treatment:

What are your goals for treatment?

**BRIAN P. LAMBERT, P.T., L.L.C.
198 SPOTNAP ROAD (SUITE C-5)
CHARLOTTSVILLE, VIRGINIA 22911**

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 (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 thirty-five 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