



RICHARD L. STONEKING, PT
Lic. No. 40QA00221200

333 North Main Street
Lambertville, NJ 08530
609-397-9390
609-397-2586 fax

1230 Parkway Avenue
West Trenton, NJ 08628
609-883-7528
609-883-5947 fax

stonekingpt.com

PATIENT INFORMATION

Patient Name _____ Age _____ Sex _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Marital Status _____ E-Mail _____

May we send periodic informational e-mails to you? (Y) _____ (N) _____

Home Phone _____ Cell _____

Employer _____ Phone _____ Occupation _____

Address _____ S.S.# _____

Spouse/Guardian Name _____ Phone# _____

Employer _____ Address _____

How did you hear about us? _____ Physician _____

MEDICAL INFORMATION

Are you under the care of a physician for any other medical needs? _____ yes _____ no

If Yes, please list _____

Are you taking any medication for any needs? _____ yes _____ no

If Yes, list _____

Any other medical information we should be aware of? _____

Person to contact in an emergency _____

Phone# _____ Relationship _____



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INSURANCE COVERAGE INFORMATION

Are you presently receiving home care services (therapy, nursing, home health aide)? Yes No

Have you recently received home care services (therapy, nursing, home health aide)? Yes No

If yes, discharge date: _____ Name of Agency: _____

Consent to Treatment: I consent to rehabilitation and related services at Stoneking Physical Therapy. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Initial _____

Authorization of Payment: I hereby assign all benefits directly to Stoneking Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. I understand that if my account is sent to collection, additional charges of up to 35% of billed charges will be added to my account for collection.

Initial _____

As a courtesy to you, our staff will verify with your insurer the physical therapy coverage limitations including deductible, co-pay, precertification and referral requirements, etc.

This is not a guarantee that verification obtained by telephone communication is 100% accurate. For that reason we encourage all patients to verify their own benefits as an added measure of safety.

Initial _____



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INSURANCE INFORMATION

Primary Insurance _____

Insured's Name _____

Address _____

I.D.# _____ Group# _____

Secondary Insurance _____

Insured's Name _____

Address _____

I.D.# _____ Group# _____

Insured's Date of Birth _____

WORKERS COMPENSATION CLAIMS

Our policy for filing workers compensation claims is to bill your insurance carrier or employer. The account should be paid in full by either the employer or the workers compensation insurance carrier. In the event your claim is denied by either the insurance carrier or employer, you will then be held responsible for the balance due.

MOTOR VEHICLE INSURANCE POLICY

Insurance carriers pay 80% of the first \$5000 of medical expenses. This occurs after your chosen deductible (between \$250.00 to \$2,500.00) has been met. After the \$5,000.00 threshold expenses are paid at 100%. For this reason, we ask that you furnish us with your private health insurance information as well as your automobile insurance for any unpaid portion of the bill.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature

Date

Witness Signature
