Date: _____

How did you hear about **Complete Physical Therapy**?
(please circle one) Doctor Newspaper Website Friend Family Other

Patient Name:_____SSN:_____-_____-_____
Date of Birth _____-_____-_____ Sex M F
Address:_____City_____ State _____ Zipcode_____
Home Phone_____-_____-____ Work Phone _____-_____-____ Cell _____-_____-_____
The best # to call_____-_____-_____ may we leave a message for you? Yes No (please circle)

Email Address: _____

May we **call you** or **send emails** for appt. reminders? Yes No (Please circle your preference)

Employer: _____Address _____Phone_____
Referring Physician: _____ General Physician: _____

Who may we discuss your account or care with other than yourself if needed?
Name_____ Phone_____ Relationship_____

Who is the person responsible for this account (Who is the primary for insurance if different from above)?

_____

Name Relationship Address Phone #

_____

Date of Birth Employer

Is this a Work/Auto related injury?

Workers' Compensation #: _____ Case Worker Name _____
Phone#_____ Date of Injury: _____

Auto Insurance:
Claim Number: _____Insurance Company Name: _____ Phone #_____
Adjuster Name: _____Address: _____
Date of Injury: _____

This document summarizes the agreement between **Complete Physical Therapy** and each patient who accepts treatment.

1. Consent for medical treatment

I understand and acknowledge that I am presenting myself voluntarily for outpatient physical therapy treatment. I authorize and consent to this treatment.

2. Financial agreement

By accepting the physical therapy services provided to me as an outpatient, I agree to be financially responsible for the charges billed by **Complete Physical Therapy** for the services provided . I understand that any co-payment required by my insurance company is due at each treatment session. I hereby assign insurance benefits to **Complete Physical Therapy** and authorize my insurance company to directly pay **Complete Physical Therapy**. I understand that I am responsible for unpaid insurance balances. I will also be responsible for any reasonable collections or attorney fees incurred by **Complete Physical Therapy** related to costs of turning my account over for collection.

3. Private Pay

I understand that I can choose to pay privately for physical therapy and that payment is due at each treatment session. I further understand that I am responsible for sending my claims into my insurance company if I so desire.

4. Release of medical information

I authorize the release of necessary information to my insurance company, employer, physician, and/or third party payers. **Complete Physical Therapy** will never sell your information to a third party.

5. Privacy practices

I have received a copy of **Complete Physical Therapy's** Notice of privacy practices.

6. Policy regarding missed or cancelled appointments

I understand that **Complete Physical Therapy** requires 24 hours notice for cancellation of an appointment. We reserve the right to charge a $50.00 fee for appointments that are not kept or cancelled within 24 hours. Three missed appointments without notice will result in a discharge from physical therapy.

6. I have read this document and consent to physical therapy evaluation and treatment by Complete Physical Therapy

_____ _____

Print Name Date

_____

Patient/Guardian signature