PATIENT INFORMATION

NAME: _____ DATE OF BIRTH ____/____/_____

ADDRESS_____ CITY_____ STATE_____ZIP_____

SEX: MALE_____ FEMALE_____ AGE_____

PATIENT EMPLOYED BY_____ OCCUPATION_____

HOME PHONE#_____ WORK_____ CELL_____

PERSON RESPONIBLE FOR ACCOUNT_____

RELATIONSHIP TO PATIENT _____ DOB____/____/_____.

ADDRESS_____ PH#_____

_____.

REFERRING DR._____ DATE OF INJURY_____/___/_____.

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY_____ SUBSCRIBER#_____.

GROUP#_____ SUBSCRIBER NAME_____ DOB__/___/____.

RELATIONSHIP TO PATIENT_____.

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES___ NO_____

INSURANCE COMPANY_____ SUBSCRIBER#_____

GROUP#_____ SUBSCRIBER NAME_____

RELATION TO PATIENT_____ SUBSCRIBER DOB___/__/____.

EMERGENCY CONTACT INFORMATION

NAME:_____PH#_____ RELATIONSHIP_____.

AUTHORIZATION FOR RELEASE OF INFORMATION (SIGNATURE REQUIRED)

I authorize Hands on Physical Therapy to provide information available as to diagnosis, treatment and prognosis, with respect to any physical condition and/or treatment of me/minor, to my insurance company or its legal representative. I understand the information obtained by use of this Authorization will only be released to my insurance company to determine eligibility for benefits or services under a plan of benefits. I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this authorization shall be valid as the original. I hereby certify that statements hereon and attached are complete and accurate.

DATE:____/___/_____. Patient's or Guardians Signature:_____.

Hands on Physical Therapy, PC

Consent for Medical Treatment

I, _____, hereby give my consent to receive medical treatment/procedures(s) provided by Hands on Physical Therapy.

_____ _____

Patient Signature Date

Consent to Treat a Minor

Hands on Physical Therapy requires authorization to treat minor children in the absence of the parent or legal guardian.

Name of Minor: _____ Date of Birth_____

_____ Date: _____

Parent(s)/Legal Guardian(s) Signature

Notice of Privacy Practice

I acknowledge receipt of a copy of the Notice of Privacy Practice from Hands on Physical Therapy.

_____ _____

Signature Date

Consent to Financial Responsibilities

Hands on Physical Therapy is committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. As a courtesy, Hands on Physical Therapy will verify coverage, obtain authorization (if required), and bill your insurance company directly for you. Unfortunately, there are no guarantees of benefit reimbursement until claims are received and processed by your insurance company. We will require you to assign all insurance company payments directly to our office to avoid any misunderstandings regarding payment for professional services. If you request your insurance company to pay you directly, we will require full payment when services are rendered.

All co-pays, co-insurances amounts, and deductibles are due at the time of service. We accept Cash, Check, Master Card, Visa, Discover or American Express.

Hands on Physical Therapy will not accept litigated claims, third party claims, or letters of protection.

The undersigned irrevocably authorizes payment directly to Hands on Physical Therapy for treatment and healthcare options. It is understood that by signing below, I am responsible for any or all charges not covered by my insurance company.

Printed Name of Patient_____ Date: _____

_____ Date: _____

Signature of Patient or Legally Authorized Representative.

Broken Appointment Policy

A broken appointment is defined as an appointment that is scheduled and not attended that is cancelled without at least 24 hour notice. A fee of **$40.00** will be assessed for each of the first 2 appointments that are broken. A fee of **$150.00** will be assessed for the third broken appointment as well as for any subsequent ones that may occur. All broken appointment fees must be paid before any additional visits.

I have read and understand the broken appointment policy:

_____ Date: _____
Patient Signature

1._____ Date: _____
Patient Signature

2._____ Date: _____
Patient Signature

3._____ Date: _____
Patient Signature

Presbyterian Centennial Broken Appointment Policy

1._____ Date: _____
Patient Signature

2._____ Date: _____
Patient Signature

3._____ Date: _____
Patient Signature Discharged: