restore
PHYSICAL THERAPY

GENERAL INFORMATION:

First Name: _____
Middle Name: _____
Last Name: _____
Preferred Name: _____
SSN: _____ - _____ - _____
Birthdate: _____ / _____ / _____
Gender: Male/Female
Pronouns: He/Him, She/her/They/Them, No Pronoun

MINOR: ◯
Parent/Guardian Name: _____
Address: _____
Phone: _____
Birthdate: _____ SSN: ____ - ____ - _____
Employer: _____

ADDRESS INFORMATION:
Billing Address: _____
Physical Address: _____
City: _____ State: _____ Zip: _____

CONTACT INFORMATION:
Primary Phone: _____ Cell/Home/Work
Secondary Phone: _____ Cell/Home/Work
Email: _____
Appointment Text Reminder*: ◯
*Note by checking the text reminder box you authorize certain PHI to be disclosed (ie: name, email, appointment information)

OCCUPATION: _____
Employer: _____ Phone: _____
Business address: _____

EMERGENCY CONTACT:
Name: _____ Ph: _____
Address: _____ Relation: _____
Closest Relative or Friend (not living with you):
Name: _____ Ph: _____
Address: _____ Relation: _____

MARITAL STATUS: Single/Married/Widow/Divorce
Spouse Name: _____
Employer: _____ Ph: _____

CLAIM TYPE: Motor Vehicle Accident/Workman's Comp
If yes, Date of injury: _____ State: _____
Claim #: _____

Date of Surgery (if applicable): _____

Do you have a follow-up appointment with the doctor who referred you to physical therapy?
- ○ YES, date of appointment: _____
- ○ NO, I am to call the doctor to schedule a follow up
- ○ NO, doctor did not request to see me again

REFERRING PHYSICIAN: _____
PRIMARY CARE PHYSICIAN (PCP): _____

INSURANCE INFORMATION:
Primary Insurance: _____
ID#: _____ Grp#: _____
Insurance Phone #: _____
Claims Address: _____
Secondary Insurance: _____
ID#: _____ Grp#: _____
Insurance Phone #: _____
Claims Address: _____

Restore Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered individual and the insurance company***. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

CONSENT FOR TREATMENT

I hereby consent to such physical therapy procedures as may be rendered by Restore Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Restore Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $20.00 fee will be charged for returned checks. Restore Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Restore Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

Less than 24-hour Cancellation/No Show Policy: It is important that you attend your scheduled appointments. It is difficult for us to assist you when you are not here. **We do charge the patient, not the insurance a $50 fee for cancellations less than 24-hour notice and/or if you do not show to your appointment. After 2 no shows, all future appointments will be canceled, and you will be on a call list. You will be discharged as a patient if you have 3 cancellations less than 24-hours and/or 3 no show appointments.** ***The $50 policy fee does not apply to Medicaid or Medicare.*** Every attempt will be made to make your physical therapy appointments as convenient as possible.

_____
Signature (Parent/Guardian if minor patient) **Date**

HIPAA NOTIFICATION

I acknowledge that I have been informed and notified of the whereabouts of Restore Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

_____
Signature (Parent/Guardian if minor patient) **Date**