

# Patient Information Form



Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_ Sex: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

## How did you hear about us?

- Physician (list name): \_\_\_\_\_
- Friend (list name): \_\_\_\_\_
- Phone Book
- Newspaper/ Magazine
- Other (list): \_\_\_\_\_

**I do hereby consent to the evaluation and initiation of treatment by First Choice Physical Therapy. I authorize the staff to perform any necessary services needed during diagnosis and treatment.**

**I also authorize First Choice Physical Therapy to release any information** required to process insurance claims, communicate with my Physician/ other Therapist or any other persons/ pertinent medical offices concerning my treatment(s) here at First Choice Physical Therapy.

I understand that I may be assessed a **\$25 missed visit fee** if I do not give at least a **24 hour notice of cancellation** or do not show at all for my scheduled appointment.

**Privacy Practices Acknowledgement:** I have been provided an opportunity to review the Notice of Privacy Practices. I understand that at any time I can request a copy for further review.

**I understand that there may be times when my insurance company may erroneously send payments to me rather than directly to First Choice Physical Therapy for services rendered at their office.** I understand and agree to bring in any of these checks within 3 days of receipt of the check. I also understand that should payment be sent to me and I cash the check, that I will be held fully responsible to reimburse First Choice Physical Therapy for said check.

**I understand that First Choice requires payment in full for all services rendered at the time of visit,** unless other arrangements have been made with the office or billing manager. **If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any expenses incurred in collecting my account** (attorney's fees, court costs, collection agency fees and/ or interest on the amount due that will accrue at the maximum amount allowed by law associated with the collection process).

Marital Status (circle): S M D W  
Insurance Company: \_\_\_\_\_  
Patient's relationship to policy holder:  
 Self  Spouse  Child  Other

If the patient is not the policy holder, please list:  
Policy holder's name: \_\_\_\_\_  
Policy holder's DOB: \_\_\_\_\_  
Policy holder's SS#: \_\_\_\_\_

If you have secondary insurances, please list below:  
\_\_\_\_\_  
\_\_\_\_\_

## In the event of an emergency:

Who should we contact? \_\_\_\_\_  
Relation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

**Guarantor Agreement:** By signing in the space below, I hereby agree that all charges connected with this treatment not covered by any insurance, program, sponsorship or other third party coverage I may have, are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are those listed in the current billing Charge Manuals, which are available for inspection upon request and incorporated herein by reference.

**I hereby acknowledge that if First Choice Physical Therapy has agreed to bill my insurance or other third party carrier, it has agreed to do so as a courtesy** and that First Choice has the right should First Choice deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third party carrier, unless First Choice and my insurance company or third party carrier have agreed that I will not be billed.

**I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status, insurance, or contact information.**

If the patient is under 18 years of age then the legal guardian of said patient authorizes First Choice Physical Therapy, or any associate of First Choice or whomever may be designated as an assistant to render medical care to the patient. I consent to any care, which encompasses any Physical Therapy treatment that the Physical Therapist or his/her assistant may deem necessary for my child's health and well-being.

**Patient/ Responsible Party signature:** \_\_\_\_\_  
Lifetime signature

**Social Security Number:** \_\_\_\_\_  
**Date:** \_\_\_\_\_