PHYSICAL THERAPY

Patient Information

Patients Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

SS#: _____ Email: _____

Phone#'s: (Home) _____ (Cell) _____

Emergency Contact: _____ Relation: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Method of Communication: ☐ Email ☐ Text Message ☐ Phone

I Agree to Receive Emails From Fit PT (for therapist and clinic communication only): ☐ Yes ☐ No

Who Can We Thank For Your Referral: _____

Authorization

Your signature below acknowledges you understand and agree to the following:

Authorization for Information Release:
I authorize Fit Physical Therapy to furnish my insurance company with medical information they may request regarding your condition or treatment. I also authorize Fit Physical Therapy to communicate with my referring health care provider regarding any medical information needed for treatment. Furthermore, I authorize my referring healthcare provider to release any Diagnostic Reports, Imaging (X-Rays, MRI, CT Scans), and surgery reports related to my care to Fit Physical Therapy.

Privacy Notice and Patient Bill of Rights:
I have read and understand Fit Physical Therapy's Privacy Notice and Patient Bill of Rights.

Authorization for Treatment:
I authorize Fit Physical Therapy to provide physical therapy treatment to the above named patient.
I am at least 18 years of age and/or the legal guardian/guarantor of the above named patient.

Financial Policy
I agree to pay for all services rendered. I agree to pay any and all amounts that my insurance company applies to any unmet deductible. If my insurance company requires a co-payment, I agree to pay it at the time of each appointment. If my insurance pays on a percentage basis, I agree to pay an average amount per visit based on what my percentage is. This is to be negotiated and agreed upon with the office manager. I understand that I will be fully responsible for any services deemed as non-covered or denied by my insurance company. I agree to pay for any medical supplies that are not covered by my insurance, under my policy. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits by an insurance company.

If my insurance company is out-of-network with Fit Physical Therapy and/or if there is a limit on the number of units per visit, I agree to pay the difference between what is paid by my insurance company and the services rendered by Fit Physical Therapy. I assign insurance benefits for all services rendered by permitting payment directly to FIT Physical Therapy for services rendered.
Payment can be made in the form of cash, check, and/or credit card (Visa, MasterCard). There will be a $25.00 per check charge for all returned checks.

No Show Policy
I understand that I will be charged a $30.00 fee if I fail to keep an appointment without calling to cancel or reschedule 24 hours in advance, unless in case of emergency or illness. This missed visit will beconsidered a "No Show" and the $30.00 no show fee will be my responsibility. My insurance will not bebilled.

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient: _____

Signature of Patient and/or Legal Guardian: _____ Date: _____