Patient Information

Full Name:	DOB:	Today's Date:
Address:	City/State:	Zip:
Phone: (cell)	(home)	(work)
Email:		Sex: M F
Referred By:	Referring Physician Phone:	
Address:	City/State:	Zip:
Primary Care Doctor:	Office Phone:	
Address:	City/State:	Zip:

Condition Information

Is your condition due to an accident? Y N	Date of Accident:	
Type of Accident: Auto/Work/Home/Other	If other, please explain:	
Did you file a claim? Y N	Adjuster's Name:	
Claim #:	Adjuster's Contact Number:	
Do you have an attorney? Y N	Attorney's Name:	Attorney's Contact Number:

Consent for Treatment

A licensed Physical Therapist will perform your evaluation and treatments. A variety of treatment techniques may be performed, as allowed under the physical therapist's scope of practice. I hereby consent to Physical Therapy Evolution providing care and treatment for my condition.

Cancellation and No-Show Policy

If I am unable to keep my appointment, I understand that a 24-hour notice is required (if my appointment is on a Monday, I understand cancellation notice is required on or before the preceding Friday), or I will incur a full appointment charge. We appreciate your understanding of this policy.

Privacy Practice Acknowledgement

I acknowledge that I have read the Notice of Privacy Practices with an effective date of March 5, 2015. I understand that I may receive a copy of this notice upon request at any time, and that I may inquire at the front desk at Physical Therapy Evolution with any questions I may have regarding the Notice of Privacy Practices.

____ ___________________________

Responsible Party Signature Date

Assignment of Medical Insurance Benefits

Thank you for choosing Physical Therapy Evolution. We will work with you and with your insurance carrier to submit claims, but would like you to understand our office policy regarding insurance assignment. Payment is expected at the time of service unless we accept assignment from your insurance carrier or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

You acknowledge that it is your responsibility to:

- ➢ Provide complete, current information on medical insurance coverage for yourself (or the patient if under 18), including presenting a valid insurance card and photo ID at the time of service.
- ➢ Pay applicable co-payment or co-insurance at the time of service, if required. A minimum per-visit charge may be asked for high deductibles that have not yet been met.
- ➢ Present a valid referral or authorization number for all services (if required by your insurance company). Your primary care physician or referring specialist can help if needed.
- ➢ Inform us if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
- ➢ Make payment within 30 days on any balance on your account for amounts due such as deductibles, coinsurance, co-payments or non-covered services.
- ➢ Verify that this provider is in network with your particular insurance plan under your insurance carrier.

You are ultimately responsible to pay the medical bill if your insurance company does not honor the assignment of benefits in whole or in part.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy/completeness of the medical insurance coverage information.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Physical Therapy Evolution.

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	