Physio Pro

A physical therapist owned private practice

Patient Information

To ensure accurate billing, our office will require all information is updated before every re-start or new treatment of care.

Name (Last, First, MI): _____ Social Security Number: _____

Date of Birth: ____/____/____ Age: _____ Marital Status: Single Married Divorced Widowed Gender: M F

Home Address: _____
(street address) (apt/unit #) (city) (state) (zip)

Billing Address: _____
(street address) (apt/unit #) (city) (state) (zip)

Home #_____ Cell #_____ Work #_____

Email:_____ Are you interested in appointment reminders? TEXT EMAIL

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship: _____ Phone:_____

Have you had previous physical therapy treatment? YES NO Treatment Area:_____

Dates of Treatment:_____ How many visits did you receive?_____

Are you currently or have you recently had Home Health Therapy? YES NO If yes, what is your discharge date?_____

Please provide all your current insurance information to the front desk.

Insurance Policy Holder:_____ DOB:_____ Relation:_____

For Auto or Work Compensation Patients: Please note we do not accept third party claims!

Company:_____ Claim #_____ Date of Injury:_____

Adjuster/Nurse Case Manager:_____ Phone #_____

Is an attorney involved in your case? YES NO

Attorney:_____ Phone #_____

-Please Turn Over-

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Please review the provided information packet including our HIPAA and payment policy before signing. Please note that without acknowledgement of our policies we may refuse or delay non-emergency services.

Consent to Treat:

I authorize Physio Pro P.C. to render services deemed medically necessary for the treatment of the above named patient. I have read and agree to Physio Pro P.C.'s Notice of Privacy Practices (HIPAA).

*Initial*_____

Financial Responsibility:

I understand that it is my responsibility to know my insurance benefits and any referral/authorization requirements. Any balance after insurance has paid or denied my claims will be my responsibility to pay. I also agree that failure to pay any balance due to me will result in my account being turned over to a collection agency. I aware I am responsible for any reasonable collection fees, including any attorney fees.

*Initial*_____

Payment Policy:

I have read and understand Physio Pro P.C.'s payment policy.

*Initial*_____

Assignment of Benefits/Medical Release of Information:

I authorize payment to be made directly to Physio Pro P.C. I authorize the release of any medical information necessary to process payment for services rendered.

*Initial*_____

Cancellation/No-Show Policy:

I have read and understand Physio Pro P.C.'s cancellation and no-show policy. I understand payment for missed appointments will be due before my next scheduled appointment.

*Initial*_____

I certify that all of the above information is true and correct. I will notify

Physio Pro P.C. of any changes to my personal or insurance information immediately.

Signature (Patient/Guardian):_____ Date:_____

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