Centralia Physical Therapy Chehalis Physical Therapy

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

First Name _____ Last Name _____ MI _____ Nickname _____

Date of Birth _____/_____/_____ SSN _____ Gender _____ Marital Status _____

Mailing Address _____

City_____ State _____ Zip _____

Home Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Email _____

How would you like to receive reminder messages about your appointments?

Please select ONE option: _____ Text Message _____ Phone Call _____ Email

EMPLOYER (at time of injury / onset of pain)

Name_____ Phone (_____) _____-_____

Address_____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Carrier _____ ID # _____ Group #_____

Subscriber Name _____DOB_____ SS# _____

SECONDARY INSURANCE

Carrier _____ ID # _____ Group #_____

Subscriber Name _____DOB_____ SS# _____

MESSAGE AUTHORIZATION

I authorize CPT to leave detailed information on my phone message system.

X Signature: _____ **Date:** _____

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PRACTICE POLICIES

AUTHORIZATION TO TREAT, RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Centralia/Chehalis Physical Therapy to evaluate and treat me (or my legal dependent). I authorize Centralia/Chehalis Physical Therapy to release to my insurance company(ies) any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at Centralia/Chehalis Physical Therapy. I hereby agree to full responsibility for all expenses incurred by myself, or minor child.

FINANCIAL POLICY AND AGREEMENT

* Insurance co-payments are required at check-in. We accept most major credit cards, cash and checks.
* Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does or does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

* I hereby acknowledge I have been offered a copy of the Notice of Privacy Practices/Privacy Rights to review.
* Other than my insurance companies and/or referring physician, ***other parties*** whom I give permission to obtain information on my behalf regarding my (or my dependent's): medical records, treatment, insurance, billing, appointment info include:

***may also be used as an Emergency contact, in the event of an Emergency**

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

NO-SHOW/LATE CANCELLATION POLICY

Please be advised, a minimum of 24 hours' notice is required if you need to cancel an appointment. If you no-show or cancel without sufficient notice, you may be placed on a same-day call-in basis. This means you will have to call in the morning to schedule an appointment that same day. We may not be able to accommodate all same-day call-in requests.

I HEREBY ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE PRACTICE POLICIES OUTLINED ABOVE:

X Signature: _____ **Date**: _____