PATIENT INFORMATION

Patient Name:_____
Last First

Date of Birth: _____ Male: ☐ Female: ☐

Address:_____

City: _____ State:_____ Zip:_____

Home Phone: _____

Cell Phone: _____

~ Would you like appointment reminders by email?

Email: _____

Patient Employer:

Name:_____

Work Phone: _____

Occupation: _____

OFFICE USE ONLY
Patient Account# _____

Social Security #: _____

Is this the result of an auto accident? (Y/N) _____

Work Related? (Y/N) _____

Insurance Co: _____

Claim #: _____ DOI: _____

Responsible Party (*For patient's under 18*):

Name: _____

Address: _____

Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

Please initial:

Consent to Treatment: I consent to rehabilitation and related services at Peak Physical Therapy. In doing so, I understand that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

Treatment of Minors: I, as parent/guardian of a minor receiving treatment, understand and agree that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

Liability: I know and agree that Peak Physical Therapy is not responsible for loss or damage to personal valuables. _____

Waiver and Release: I release Peak Physical Therapy from all liability, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, emergency medical technician, physician or urgent care services. _____

Authorization of Payment: I assign all benefits directly to Peak Physical Therapy and authorize release of any medical records necessary to facilitate my treatment to process medical claims. I understand that in the event my insurance company does not pay for the services I receive, I will be financially responsible for payment. _____

Notice of Privacy Form: I acknowledge the receipt of the Peak Physical Therapy Notice of Privacy Practices form. _____

Cancellation Policy: Any appointments not rescheduled or cancelled at least 24 hours in advance will result in a charge of $20 to your account. _____

Returned Check Policy: A $25 fee will be issued for a returned check of insufficient funds. _____

Patient/Guardian Signature: _____ Date:_____