

PEAK PHYSICAL THERAPY

Patient Information

Patient Name: _____
Last First

Date of Birth: _____ Male: Female:

Address: _____

Social Security #: _____

Marital Status: _____

City: _____ State: _____ Zip: _____

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

E-mail: _____

Work Related? (Y/N) _____ Auto (Y/N) _____

Home Phone: _____

Responsible Party:

Cell Phone: _____

Name: _____

Patient Employer: _____

Address: _____

Name: _____

Emergency Contact:

Work Phone: _____

Name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship: _____

Occupation: _____

Prescribing Doctor: _____

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 non sufficient funds.

Patient/Guardian Signature: _____ Staff Initials: _____ Patient Acct: _____