



PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Sex: M F Marital Status: S M D W Student: No FT PT Work Status: No FT PT

Social Security No: _____ - _____ - _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Email: _____

Patient's Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? ___ Physician ___ Been Here Before ___ Phone Book ___ Internet ___ Print Ad ___ Walk-In

Family Member ___ If so, name: _____ Friend ___ If so, name: _____

Is this injury work related? N Y (circle one) Date of injury: _____ If yes, in what state did the accident occur? _____

Is this injury related to a motor vehicle accident? N Y (circle one) Date of injury: _____ If yes, in what state? _____

Reason for visit: _____

How did accident/injury occur? _____

Referring Physician: _____ Primary Care Physician: _____

Date of next doctor's appointment: _____

PATIENT'S RELEASE OF INFORMATION AUTHORIZATION

There may be times when it is necessary for CPT to release personal health and or financial information to an individual that is not the patient. In accordance with Federal Regulations we can not release any information without written consent from the patient, please take a moment to complete this section. If you want us to discuss your information with (spouse, parent, neighbor and etc.), please list them below.

Financial Information: ___ Yes ___ No Medical Information: ___ Yes ___ No Scheduling Appointment ___ Yes ___ NO

_____: This authorization will expire on this date: _____

_____: This authorization will expire upon my date of discharge.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Signature: _____ Date: _____

Benefit Release Information: I authorize **Colleyville Physical Therapy and Sports Rehabilitation, P.C.** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to **Colleyville Physical Therapy and Sports Rehabilitation, P.C.** I also authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Authorization of treatment: I authorize **Colleyville Physical Therapy and Sports Rehabilitation, P.C.** to provide therapy services to myself _____ or to (my legal dependent) _____. I understand, I have the right to refuse therapy services at any time. I further understand no guarantees have been made by any representative of **Colleyville Physical Therapy and Sports Rehabilitation** as to the outcome of this therapy.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

HIPAA Privacy Practices Acknowledgment: I have received the notice of privacy practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Cancellations and No-Shows: We take this subject seriously, because it can make difference between whether you succeed in your treatment or not. Showing up for these visits is very important in achieving your goals in therapy. Our appointments are made for an hour or greater, therefore when you do not show or fail to give adequate notice of a cancellation we are left with a large gap in our daily schedule, when another patient might have needed an appointment.

We require 24 hours notice of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

There will be a \$25.00 charge for a cancellation or no show without proper notice. This charge will not be covered by your insurance plan and is your responsibility. Worker's Compensation and PIP patients; documentation has to be made of any missed appointments and forwarded to your case manager and primary care physician.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)