WELCOME TO ACCELERATION PHYSICAL THERAPY

Today's Date: _____/_____/_____ Have you had other *Physical, Massage, Speech or Occupational Therapy* during the current calendar year? (circle one) Yes or No

If YES, where?_____

Patient Name:_____Sex M/F **E-mail**_____
(First) (M.I.) (Last)

Address: _____ **City**: Spokane Nine Mile Falls Other:_____ **Zip Code**: _____

Home Phone: _____**Cell Phone**: _____ **Work Phone**: _____
Can we call you at work? Yes / No

Marital Status: (circle one) Single - Married - Separated - Divorced - Widowed

Date of Birth: _____ / _____ / _____ Social Security #_____

Employment Status:(circle one) Full Time - Part Time - Student - Retired - Unemployed

Patient's Employer_____
(Business Name) (Business Address & Phone Number)

Spouse's Name: _____ **Spouse's Employer**: _____**Spouse's** DOB:____/____/____

Spouse's Contact #_____

Guarantor Name (If Patient is a Minor/Child):_____***Relationship to Patient:***_____

Home Phone:_____

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Primary Physician: _____**Date last seen**: ____ /____ /_____

Referring Physician: _____**Date last seen**: ____ /____/_____

Emergency Contact: _____ Phone:_____
(Name & Relationship to Patient)

Who can we thank for your referral? _____

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Do you currently have an open PIP claim under **your** auto insurance? Yes No
Have you sustained an on-the-job injury? Yes No

Complete only if you have an AUTO or ON-THE-JOB injury claim:
Name of Insurance Co: _____ Phone: _____

On-The-Job/Employer & Address at the time of injury:_____

Have you had physical therapy for this accident? Yes No If yes Where _____ When_____/_____/_____

Claim # _____ _____ Date of Injury: ____/_____/_____ Contact Person: _____

State of accident: _____ Attorney:_____ Phone:_____

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Primary Medical Insurance: _____ Policy Holder:_____

Secondary Insurance: _____ Policy Holder _____

PLEASE PRESENT INSURANCE CARD AND COPAYMENT AT THE TIME OF TREATMENT

**** CONTINUED ON BACK ****

I hereby authorize treatment by Acceleration Physical Therapy for the above mentioned patient. I understand that I am financially responsible for all charges incurred for services rendered regardless of litigation, insurance reimbursement, or pending Labor & Industry Claims. I understand that the parent accompanying a minor for any treatment will be responsible for payment. I authorize the release of any necessary information requested by my insurance company and/or attorney. I authorize payment directly to Acceleration Physical Therapy.

Cancellations or change of appointments must be made by 12:00 the day prior to the scheduled appointment. If a patient fails to show for two (2) scheduled appointments or cancels an excessive number of times, there will be a fee charged to be determined by your physical therapist.

Many insurance companies DO NOT consider supplies a covered benefit. We will make every attempt to get these paid for, but you may be asked to pay at the time of service for a supply we know is not a covered benefit.

As a courtesy, we will bill your insurance company for you **IF we are given a copy of your insurance card and all pertinent information to do so.** Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract, therefore, it is the responsibility of the patient to determine if there is coverage for the services being rendered, obtain prior authorization if necessary and follow up with unpaid visits if necessary.

ALL co-payments are due on the day of treatment. We have a signed contract with most insurance companies that state we are to collect co-pay on the day of your scheduled appointment.

If you are involved with a third party litigation, arrangements will need to be made with the billing manager before any further appointments.

All patient balances older than 60 days are subject to a 1% per month interest/billing charge.

Notice of Privacy Practices-Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy these records. You may also ask to have these records corrected. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about them by contacting the Medical Records/Privacy Officer or Office Manager.

Our notice of Privacy Practice describes in more detail how your health information may be used and disclosed.

By my signing below, I authorize permission for the staff of Acceleration Physical Therapy to release information to the following:

My Physician(s):_____My Insurance Co._____

The following person(s) of my choice: _____

I also give permission to call/leave messages at my home/place of employment regarding appointments etc:
Home: Yes _____ No _____ Place of Employment: Yes_____ No_____

By my signature below, I acknowledge that I am aware of the Notice of Privacy Practices and authorize the above mentioned release of information.

Patient or Parent Sign _____Date_____

_____ _____
(Printed name if signed on behalf of patient) (Relationship)

This form will be retained in your medical file