PATIENT INFORMATION FORM

Name:_____ Preferred Name_____

Address:_____City:_____Zip:_____

Birthdate_____ Marital status_____

Employment:_____

Email: _____

Primary Phone: _____ Cell: _____

Would you like to receive reminders via text? : ☐ Yes ☐ No

Phone Carrier:_____ Is it okay to leave a confidential message: ☐ Yes ☐ No

Emergency contact:_____

Relationship_____ Phone :_____

Primary insurance:_____Member ID:_____

Subscriber:_____Relationship to subscriber: _____

Group number:_____ Policy number:_____Claim number:_____

Physican information

Referring physican:_____Date of injury:_____

Auto related ☐ Yes ☐ No Work related ☐ Yes ☐ No Accident related ☐ Yes ☐ No

Attorney invoved ☐ Yes ☐ No

If yes, name:_____Phone:_____ Fax:_____

Medications list:_____

_____

_____

Authorized Designated Individuals

Please list below the individuals you would like to have access to your private health information. If you would prefer not to designate authorized individuals, PLEASE WRITE "**NONE**" AND SIGN.

Name:	Relationship:
Name:	Relationship:

I hereby authorize these designated parties to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Patient/Guardian Signature:	Date:

Acknowledgement and Consent of Terms and Policies

By signing, I certify that I have read the attached documents "*Notice of Patient Information Practices*" and "*Note to Our Patients Regarding Billing, Payment, and Office Policy*" and furthermore agree to comply with terms of therein. These documents include but are not limited to the following clauses which I have read, understand, and with which I agree to comply:
Because this is a small private business, late cancellations and failed appointments affect us greatly and we adhere to our cancellation policies.

1. "I understand that cancelling my appointment with less than 24 hours of notice or failing to keep my appointment will result in a **$75 fee**, to be paid by me personally, NOT by my insurance!"
2. "My copayment or out-of-pocket payment is due at the time of service. If I do not pay at the time of service, a **$25 billing fee** will be added to my balance on each statement mailed out to me.
3. For my convenience, PTI accepts all major credit cards as well as personal checks. A **$50 fee** will be charged for any bounced checks.
4. PTIs fee for medical records when released to the patient is **$50**. When requested by any other party (lawyers, non-referring MDs, etc) the **fee is $75**. These fees are non-negotiable.
5. Accounts that are delinquent past 90 days will be automatically submitted to collections for payment. If we have to send your account to collections, there will be an extra fee added to your balance. Once in collections we are unable to reduce/void any fees. Please note: collection agency has their own interest rates that they add to your account balance.

PTI provides text and email reminders as a courtesy, but it is **MY RESPONSIBILITY** to attend my appointment in the event of no reminder. **Please NOTE: you can not reply to email or text reminders you must call in (voicemail is available after hours)**

I understand that Physical Therapy Innovations may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that copayment and deductibles are due at the time of service, except pool therapy copayments, which I may pay in advance or have billed to me. I authorize the participation of PT and PT assistant graduate candidates in my treatment. I understand that I am ultimately financially responsible for any services provided by Physical Therapy Innovations, Inc. By signing below, I agree that I have been given a copy of the full list of PTI policies to keep as a reference.

Patient/Guardian Signature:	Date:

Assignment and Release

I authorize my insurance benefits be paid directly and mailed to: **Physical Therapy Innovations, Inc. 425 Kearney St. El Cerrito, CA 94530**. If my policy prohibits direct payment to the health provider, then I hereby also instruct my insurance company to make the check out to me but **mail it in care of Physical Therapy Innovations, Inc**. I understand I am responsible for any amount not covered by my insurance, and for any costs incurred for collection on my account. I authorize Physical Therapy Innovations, Inc. to furnish information concerning my illness and treatments to my insurance carriers. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient/Guardian Signature:	Date: