Patient Information

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell #1: _____ Home/Work #2: _____

****Please circle your preferred phone number for appointment reminders and correspondence****

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Language: ☐ English ☐ Spanish ☐ Farsi ☐ Arabic ☐ Other: _____

Employer Information of Insured Party **(Workers Comp insurance only)**

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____ Contact: _____

Emergency Contact

First Name: _____ Last Name: _____

Relationship: ☐ Spouse ☐ Friend ☐ Parent ☐ Other: _____

Day Phone: _____ Evening Phone: _____

Have you EVER been diagnosed with any of the following? (Please check all that apply.)

☐ cancer (type)_____	☐ diabetes	☐ rheumatoid arthritis
☐ heart disease	☐ stroke	☐ multiple sclerosis
☐ high blood pressure	☐ depression	☐ kidney/liver problems
☐ asthma	☐ anemia	☐ stomach ulcers
☐ osteoporosis	☐ lung problems	☐ chemical dependency (i.e., alcohol)
☐ epilepsy	☐ thyroid problems	☐ Parkinson's disease
☐ pacemaker inserted	☐ Other_____	☐Other_____

Please list ALL current medications: _____

_____

ALLERGIES: _____

Date of Injury: _____

Reason for therapy:_____

Please list your goal(s) for physical therapy: _____

_____

****Please notify us if you have secondary or supplemental insurance.*

I certify that the information provided above is correct.

Signature: _____ Date: _____

Consent to Therapy

I, _____ hereby authorize Mobility Physical Therapy to perform the therapeutic procedures, as outlined below, during my course of treatment.

I have asked all the questions I feel are important in deciding to proceed with the evaluation and treatment of physical therapy and have received answers to my questions to my satisfaction.

I understand that Mobility Physical Therapy offers no guarantee of a successful outcome for the condition/s that I am seeking treatment for.

I understand that at anytime throughout my course of treatment with Mobility Physical Therapy, I may consult with other therapists, physicians or other medical professionals regarding my condition.

I understand that I may refuse or decline any forms of therapy at any time provided by Mobility Physical Therapy. Any therapy performed upon myself is with full consent.

I certify that I have read the above statements and agree to the terms that apply. I understand the risks, if any, that are associated with the treatment provided by Mobility Physical Therapy.

Signature _____ Date _____

PATIENT AGREEMENT

Privacy Policy

I hereby authorize and request Mobility Physical Therapy Inc. to release any and all records to my insurance company, attorney, employer, case manager, physician or other health care providers related to my condition and/or illness being evaluated and/or treated.

I hereby authorize the release of any and all medical records from other health care providers to Mobility Physical Therapy Inc. related to my condition.

I have read and understand this facility's privacy practices according to HIPAA guidelines. Initials:_____

Payment Guarantee

I hereby authorize payment directly to Mobility Physical Therapy Inc. for all evaluations and treatment rendered by their employees or any other related person/s.

I understand that all payments and/or co-payments for treatment rendered by Mobility Physical Therapy Inc. are due in full at the time of service. I agree to reimburse Mobility Physical Therapy Inc. for any and all charges not paid for by my insurance company or other related party regarding my evaluation and treatment. These charges will be paid by myself in full upon notice from Mobility Physical Therapy Inc. I will also notify Mobility Physical Therapy Inc. of any changes in Insurance coverage and/or providers during the course of treatments; and will be responsible for all charges if notification is not made.

I understand that I am responsible for the reimbursement to Mobility Physical Therapy Inc. of any appointments that result in a no show or a cancellation with less than twenty-four hours notice. **There will be a Seventy dollar charge for such missed appointments.** Arriving 15 minutes after your scheduled appointment will be considered a no show and is subject to the cancellation policy. Missed appointment fees are due in a timely fashion (30 days). I agree to pay the missed appointment(s) fee(s) in a timely fashion and understand that if payment is not paid, late charges will incur and I will be sent to collections and will be responsible for associated fees and interest.

There will be a Twenty-five dollar charge for any cancelled or returned checks.

Any duplicate or copy of this agreement will be treated as an original and valid for all circumstances within this document.

Print: _____

Signature: _____ Date: _____

Mobility Staff signature confirming patients' understanding of policy: _____ Date: _____