Patient Information

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell #: _____ Home/Work #: _____

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

*Employer Information of Insured Party (**Workers Comp Insurances 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: _____

Please describe what bring you to physical therapy today:

_____

_____

_____

_____

_____

Date of Injury (IF APPLICABLE) : _____

Nature of Injury (IF APPLICABLE): _____

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.

Patient Signature: _____ Date: _____

(Parent/Guardian signature if patient is a minor)

FINANCIAL POLICY

We are happy that you chose us for your physical therapy treatment. Please carefully read, initial, and sign this agreement. Let our office know if you have any questions:

Initial: _____ 1) Patients are responsible for knowing their own health insurance coverage. This includes, but is not limited to: eligibility, maximums, deductibles, co-payments, frequency limitations, and waiting periods. As a courtesy, we can help you verify your physical therapy benefit information. However, it is ultimately ***YOUR*** responsibility to know what is covered under your health insurance.

Initial: _____ 2) 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.

Initial: _____ 3) You will need to pay your portion of the charges as you go. This includes annual deductibles, co-payments, and charges your insurance plan refuses to pay. **Any balance on your account remaining after we have received payment from your health insurance is expected to be paid within 30 days**.

Initial: _____ 4) There will be a $25 charge for any cancelled or returned checks.

Initial: _____ 5) Patients without insurance coverage will be expected to pay for treatment on the date that services are rendered – **no exceptions**.

Initial: _____ 6) Account balances **60 days** or older will be subject to a finance charge of 2% per month. Account balances over **90 days** old will be referred to our collection agency unless prior arrangements have been made. All collection expenses are the account holder's responsibility.

Initial: _____ 7) 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 24-hour notice. **There will be a $70 charge for such missed appointments.** Missed appointment fees are due in a timely fashion within 30 days. We understand these things happen from time to time, but if there are multiple occurrences where you do not call us in advance to cancel your appointment, you will be asked to find another provider. We do not like to discharge patients from our practice, so please be respectful and let us know if you cannot make it.

Initial: _____ 8) If have any changes to your health care plan, it is ***YOUR*** responsibility to notify us of such changes.

Initial: _____ 9) 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.

By signing below, you acknowledge that you have read this policy and agree with the terms. Your signature below also assigns insurance plan payments directly to the office. Any duplicate or copy of this agreement will be treated as an original and valid for all circumstances within this document.

Print Patient Name: _____

Patient Signature: _____ Date: _____

(Parent/Guardian signature if patient is a minor)

Text Message Informed Consent

I give permission to Mobility Physical Therapy, Inc. staff to communicate by text message (also known as SMS). This form provides information about the guidelines for text communication and how we use this form of communication. It will also be used to document your consent for communication with you by text message.

1. **Conditions for the use of text messages**: Mobility Physical Therapy, Inc. cannot guarantee but will use reasonable means to maintain security and confidentiality of information sent and received. You must acknowledge and consent to the following conditions:
    a. **IN A MEDICAL EMERGENCY, DO NOT USE CALL OR TEXT MESSAGE, CALL 911.** Do not text message for urgent problems. If you have an urgent problem during regular business hours, please call (949) 540-0301. Urgent messages or needs should be relayed to us by using regular telephone communication.
    b. Messages should not be time-sensitive. While we try to respond to messages promptly, we cannot guarantee that any particular text will be read and responded to within any particular period of time. If you have not heard back from us, call our office to follow up.
    c. You should speak with staff persons to discuss complex and/or sensitive situations rather than send text messages regarding such situations.
    d. Clinical staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
    e. You should use your best judgment when considering the use of text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
    f. Mobility Physical Therapy, Inc. is not liable for breaches of confidentiality caused by you or any third party.
    g. It is your responsibility to follow up with staff persons if warranted.
    h. It is your responsibility to attend scheduled appointments or cancel/reschedule in compliance with our 24-hour policy, regardless of receipt of the message. Cancellations/rescheduling of appointments must be done by phone, **NOT** text message.

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of text messaging as a form of communication between Mobility Physical Therapy, Inc. staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that Mobility Physical Therapy, Inc. may impose to communicate with me by text message. Any duplicate or copy of this agreement will be treated as an original and valid for all circumstances within this document.

Ultimately, it is *YOUR* responsibility to remember your appointment day and time.

Patient Name: _____ Cell #: _____

Patient Signature: _____ Date: _____
(Parent/Guardian signature if patient is a minor)

CONSENT TO THERAPY

I, _____ hereby authorize Mobility Physical Therapy to perform the
(Print name)
procedures deemed necessary by the physical therapist during my course of treatment.

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 any time 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 me is with full consent.

I certify that I have read the above statements and agree to the terms that apply. I further agree that a photocopy of this agreement is as valid as the original. I understand the risks, if any, that are associated with the treatment provided by Mobility Physical Therapy.

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.

Patient Signature _____ Date _____
(Parent/Guardian signature if patient is a minor)