Patient Information **Dx:**

Patient Name:	**Home Phone:**
Street address:	Work Phone:
City, State, Zip:	Cell Phone:
Sex: Male □ Female □	Date of Birth:
Employer:	Soc. Sec.#:
Business address:	Marital Status:
City, state, Zip:	Physician Name:
Occupation:	Physician Phone:

Responsible Party

Name:	Date of Birth:
Relationship to Patient:	Soc. Sec.#:
Street Address:	Business Address:
City, State, Zip:	City, State, Zip:
Phone:	Business Phone:

Emergency Contact Information

Name:	Relationship:
Address:	Phone:
City, State, Zip:	

Insurance Information

Are we treating you for an injury that occurred at your place of employment or due to a motor vehicle accident? Yes □ No □

Primary Insurance:	Secondary Insurance: Yes □ No □
Phone:	Phone:

Initial: ______________________________ **Date:** _______________

Patient Reimbursement agreement

As a courtesy to our patients, we will contact your insurance carrier to obtain your physical therapy benefits. However, we are not accountable for the accuracy of the information provided. It is your responsibility to contact your insurance carrier to understand and confirm benefits and charges for services rendered.

If your insurance carrier fails to pay for services within90 days, you will be billed for all unpaid charges which are due within 60 days. Failure to pay your balance will result in collection agency assignment.

At the time of service, you are responsible for payment of your annual deductible and co-payments/coinsurance.

Cancellation, No show and Late Policy

At Belmont Shore Physical Therapy we emphasize personal attention and treatment to meet your needs and reserve your appointment time solely for you. A missed appointment also interrupts your rehabilitation program, and in partnership, we become less effective in reaching your goals and goals of your referring physician. If you are late for an appointment, you will be seen for reminder of your scheduled time so that we do not incontinence other patients.

As a courtesy to our staff and patients, **please call us to cancel at least 24 hours in advance of your scheduled appointment time. Without proper notification, a fee of $ 30.00 will be charged.**

Please sign below portentous that you read and understand the above policy.

Signature: ____ **Date:** _____________

Signature of Parent/Guardian: ______________________ **Date:** ___________

Consent to physical therapy /rehabilitation services:

I have presented myself for physical therapy services to Belmont Shore Physical Therapy and consent to examination and treatment provided by my attending physical therapist. I consent to the release of copies of my examination and/or treatment records to referring physician(s) and/or third party payer (insurance companies) for the sole purpose of communication between Belmont Shore Physical Therapy and referring physician(s) and in order to properly process claims associated with my treatment. I also understand that I must give separate, written consent to allow Belmont Shore Physical Therapy to release copies of my treatment. I Authorize Belmont Shore Physical Therapy to make inquiries as it determines necessary to confirm my coverage and my financial responsibility.

Signature: ____ **Date:** _____________

Signature of Parent/Guardian: ______________________ **Date:** _____________