

512 E COLUMBUS AVENUE 6000 W RIDGE RD

CORRY, PA 16407 ERIE, PA 16506

PH: 814/664-9346 FAX: 814/663-0169 PH: 814/315-3998 FAX: 814/315-2557

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_

HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Do we have your permission to contact you via email to keep you updated on monthly events and news? □Yes □No

**APPOINTMENT REMINDER PREFERENCE:** □TEXT MESSAGE □CALL □EMAIL □NONE

EMERGENCY CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING DR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PRIMARY CARE DR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHY ARE YOU HERE FOR THERAPY?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF INJURY/ONSET\_\_\_\_\_\_\_\_\_\_

Is this due to an AUTO ACCIDENT? 🞎YES 🞎NO WORKERS COMPENSATION? 🞎YES 🞎NO

HOW DID YOU HEAR ABOUT US?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH INSURANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY HOLDER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_

\*IF PATIENT IS A MINOR\*

RESPONSIBLE PARTY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS (IF DIFFERENT THAN ABOVE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby consent to receive care for therapy services by North Penn Therapeutics/FYZICAL. I consent to

medical treatment as is deemed necessary or advisable by the physical therapist. \_\_\_\_\_\_\_\_\_\_

**CONSENT TO RELEASE MEDICAL INFORMATION: Initial**

I authorize North Penn Therapeutics/FYZICAL to release any information acquired in connection with my therapy services including, but not limited to diagnosis, clinical records, to myself, my insurance(s), physician(s)

and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_

**CONSENT TO OBTAIN MEDICAL INFORMATION**: **Initial**

I authorize North Penn Therapeutics/FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include but not limited to x-rays, CT scans, MRI reports, operative reports, along with physician documentation. **\_\_\_\_\_\_\_\_\_\_**

**ASSIGNMENT OF INSURANCE BENEFITS: Initial**

I hereby authorize payment to be made directly to North Penn Therapeutics/FYZICAL, regardless of participation in or out of network. \_\_\_\_\_\_\_\_\_\_

**GUARANTEE OF PAYMENT: Initial**

I agree to pay any charges that my insurance does not pay. I am responsible to pay for any uncovered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but no limited to late fees, interest fees, legal fees and collection agency fees. \_\_\_\_\_\_\_\_\_\_

**NO-SHOW/CANCELLATION POLICY: Initial**

I agee to give 24 hour notice for cancellation of an appointment. If this is not provided, or if I fail to show for my appointment, I will be responsible for the no-show/cancellation fee of $20.00 per incident. I acknowledge this fee is not reimburseable by insurance. I acknowledge that three cancellations or no-shows may be cause for discharge from my plan of care. \_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES: Initial**

I acknowledge I have seen the “Notice of Privacy Practices” and will receive a written copy upon request. \_\_\_\_\_\_\_\_\_\_

 **Initial**

**I hereby certify that I understand these rights as set forth.**

**Patient/Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**