



(Please print and fill in form completely)

Date: _____

Patient Information

Name: _____ Date of Birth: _____ Gender: Male Female
 SSN: _____ Marital Status: _____
 Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 Occupation: _____ Employer: _____
 Home Phone: _____ Work Phone: _____
 Mobile Phone: _____ email: _____
 May we contact you at work or on your mobile? yes no

Emergency Contact

Name: _____ Relationship: _____
 Phone: _____

Insurance

Primary Insurance: _____
 ID Number: _____ Group Number: _____
 Insured's Name: _____ Insured's Date of Birth: _____
 Insured's Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 Insured's Employer: _____
 Relation to Insured: self spouse child other

Secondary Insurance: _____
 ID Number: _____ Group Number: _____
 Insured's Name: _____ Insured's Date of Birth: _____
 Insured's Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 Insured's Employer: _____
 Relation to Insured: self spouse child other

Referral Information

Referring Physician: _____ Phone: _____
 Primary Care Physician: _____ Phone: _____

Signature: _____ Date: _____





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Making Appointments

All physical therapy treatments are by appointment only. If a scheduled appointment must be cancelled, please call us 24 hours in advance. If appointments are broken less than 24 hours in advance you will be charged a \$25 cancellation fee.

- Please be on time for your appointments. If you are late we reserve the right to either shorten your treatment time or cancel your appointment. Please initial: _____

Financial Agreement

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience, and that I am primarily responsible for all charges regardless of my existing medical coverage. I hereby give authorization for payment of insurance benefits to be made directly to JPT, LLC for services rendered, I understand that I am financially responsible for all charges not paid by my insurance company. In the event that my insurance company forwards payment directly to me, instead of JPT, LLC, I will immediately deliver such payment directly to JPT, LLC. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. Returned checks and balances 30 days of over may be subject to additional fees. I hereby authorize this health care provider to release all information in original or copied form as necessary to secure the payment of benefits. Please initial: _____

Co-Payment

I understand and agree that I am solely responsible for all co-payments and charges incurred which are not covered under my health care plan. I authorize the release of any medical information necessary to process this claim. Please initial: _____

HIPAA Acknowledgement

I have received a copy and been made aware of the privacy practices and my rights. Please initial: _____

Authorization for Treatment - Informed Consent

I hereby consent to and authorize physical therapy treatment which, in conjunction with the judgment of a physician as indicated, may be considered necessary or advisable for the diagnosis or treatment of the above named client. I understand I have the option to refuse any or all of the treatment recommended by the physical therapist. Please initial: _____

Signature: _____ Date: _____

