PATIENT INFO

Name: _____ Gender: M / F

DOB: _____ SSN: _____ Marital Status: Married / Single

Address: _____

Primary Phone: _____ C / H / W Secondary Phone: _____ C / H / W

E-mail address: _____

Employer Name: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

OFFICE POLICIES

1. No-show/Late Cancellation - $35 fee will be charged for the following:
   - Failure to notify us at least 24 hours in advance to cancel an appointment
   - If you do not show up to your scheduled appointment
   - If you are more than 15 minutes late

2. Co-pays, co-insurance, and fees for service are due on the scheduled appointment day

3. Please refrain from use of your cell phone for verbal or text communication during physical therapy sessions to protect the privacy of other patients.

4. Regardless of insurance coverage, I understand that I am financially responsible and liable for all charges and fees assessed for professional services rendered.

5. If my insurance has not paid within 60 days, I am responsible for any balance due.

6. In the event that my insurance company forwards payment for services rendered by Balance Physical Therapy, Inc. to me, I will promptly deliver such payment to Balance Physical Therapy, Inc.

7. If it becomes necessary for Balance Physical Therapy, Inc. to commence legal action for the collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred to collect said charges including: collection fees, court costs, and attorney fees.

8. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjustor, or attorney involved in this case for the purpose of processing claims and securing payment benefits.

9. Any additional paperwork not requested by a physician or a physician's office is subject to additional charges.

Print Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (last page of packet)

I acknowledge that I have received and reviewed the Notice of Privacy Practices for Balance Physical Therapy, Inc.

Signature: _____ Date: _____

CONSENT TO TREAT A MINOR (complete only if patient is under the age of 18)

I, _____, being the parent/legal guardian of _____ a minor age of _____ do hereby consent, authorize, and request Balance Physical Therapy, Inc. and its associates to administer such treatment as deemed advisable, necessary, or requested for the above named minor. I agree to hold Balance Physical Therapy, Inc. and their associates free and harmless from any claims, suits, damages, or complications which may result from such treatment.

Parent/Legal Guardian Signature: _____ Date: _____