

**Gwinnett Physical Therapy
PATIENT INFORMATION**

Name _____	SS# _____	Sex M ___ F ___
Address _____	City _____	State _____ Zip _____
Home Phone (____) _____	Cell. Phone(____) _____	Birth date _____
Marital Status S ___ M ___	Email address _____	Age _____
Date of injury _____	Date of surgery _____	
Emergency contact _____	Phone (____) _____	

Name of responsible party _____	Relationship to patient _____
Employer _____	Work phone _____
Address _____	City _____ State _____ Zip _____

Who may we thank for referring you to our practice? _____

INSURANCE INFORMATION

Patient's Primary Medical Insurance	
Subscriber's Name _____	Birth Date _____
Relationship to Patient _____	Policy ID _____ Group# _____
Patient's Secondary Medical Insurance	
Subscriber's Name _____	Birth date _____
Relationship to Patient _____	Policy ID _____ Group # _____

CONSENT TO TREAT

I hereby consent to evaluation and treatment by Gwinnett Physical Therapy.

Patient Signature _____ **Date** _____

FINANCIAL RESPONSIBILITY

Gwinnett PT will submit the charges for your treatment to your primary and secondary insurance company. You are responsible in full for any amounts not paid by your insurance company.

Gwinnett PT will add a 15% per annum interest on all 'patient balance' amounts if the balance is not paid in full within 30 days after it is due.

If we are required to send your account to collections, a \$75.00 fee may be applied to your account.

I have read and understand the above information regarding Gwinnett Physical Therapy's policies.

I authorize payment of medical benefits to Gwinnett Physical Therapy, for professional services rendered. I authorize the release of any medical information necessary to process this claim.

Patient Signature _____ **Date** _____

If patient is under 18 parent or guardian must sign.

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days).
- There is a \$25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) You're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

Patient Signature

Date

Interviewer Signature

Date