PATIENT INFORMATION

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____

STREET ADDRESS:_____ **CITY:**_____**STATE:**_____**ZIP CODE:**_____

DATE OF BIRTH:_____ **SEX: MALE:**_____ **FEMALE:**_____

HOME PHONE:_____ **CELL OR WORK PHONE:**_____

EMERGENCY CONTACT:_____**PHONE:**_____

HEIGHT:_____ **WEIGHT:**_____

MEDICATION LIST:_____

CANCELLATION/NO SHOW POLICY AGREEMENT

It is our desire at Advanced Physical Therapy, LLC to provide each patient with the highest quality of services in the most expeditious manner. Therefore, we provide a reserved time slot for each patient so that there is minimal waiting and each person receives individual attention.

In order for us to continue with this service, we ask that you call at least 24 hours in advance if you are unable to keep your scheduled appointment. After missing 2 appointments in a row without calling to cancel during the course of your treatment, we may discharge you from physical therapy and inform your physician, case manager and/or insurance carrier of your discharge status.

We appreciate the opportunity to provide your rehabilitation care. Thank You for your consideration to our staff and other patients who may need your appointment time, if you can't make it.

PATIENT CONSENT TO EVALUATION AND TREATMENT

As a patient of Advanced Physical Therapy, LLC, you have the right to be informed about your condition and the recommended physical therapy procedures to be used.

I voluntarily request Advanced Physical Therapy, LLC and such associates, technical assistants and other health care providers may deem necessary to treat my condition which has been/will be explained to me. I understand that the following procedures are planned for me and I voluntarily consent to authorize the procedures for evaluation and treatment of my condition.

I understand that no warranty or guarantee has been made to me as a result or cure. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment, the procedures to be used and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

PATIENT RESPONSIBILITY

I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE COMPANY DOES NOT RELIEVE ME FROM MY RESPONSIBILITY FOR THE PAYMENT OF ALL CHARGES. I ACCEPT FULL RESPONSIILITY FOR ALL CHARGES FOR SERVICES PROVIDED TO ME, TO MY MINOR/CHILD, OR THE INDIVIUAL TO WHOM I AM LEGALLY RESPONSIBLE. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

I CERTIFY THIS FORM HAS BEEN EXPLAINED TO ME AND THAT I HAVE READ IT OR HAVE HAD IT READ TO ME, AND THAT I UNDERSTAND ITS CONTENTS.

********PLEASE REFRAIN FROM WEARING PERFUME, COLOGNE OR SCENTED LOTION TO PHYSICAL THERAPY********

Patient Signature
Or Legal Representative _____ Date _____

Printed Name of Patient (If Applicable)
Or Legal Representative _____ Relationship to Patient _____

EPT Representative_____ Date_____