Fyzical Campbell

New Patient Information

Last Name	First Name	Date of Birth	Age
Address		Home Phone	
City	State Zip	Mobile phone	
Email		Fax	

I would like to receive my automated appointment reminders via: text call to home call to mobile

Emergency Contact Information

Name	Relationship	Phone

For Medicare Beneficiaries (**Please present your insurance cards for copying**)

Have you received PT or OT elsewhere this year for any reason? YES NO

Have you ever had a Worker's Compensation claim? YES NO If yes, what body part? _____

Are you seeing us today for injuries sustained in a car accident? YES NO

Referring Physician Information

Name	Phone

Acknowledgement of HIPAA Privacy Policy

We at Fyzical Campbell are required by law to maintain the privacy of and provide individuals with an explanation of our legal duties and privacy practices with respect to private health information. Copies of our policy are kept at the front desk and are available at all times.

Signature _____ Date _____

Consent to Treat

I hereby give permission to release any information requested by my insurance provider acquired in the course of my examination and treatment. I hereby authorize and direct my Medicare insurance benefits to be paid directly to FYZICAL Campbell/DeRyke & Associates, Inc as applicable. I am financially responsible for non-covered services. I hereby give permission to the therapist to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition. I hereby authorize and request any/all physicians involved in my care to release to Fyzical Campbell the complete history records in their possession concerning any treatment or examination rendered to me in the treatment of this diagnosis.

Cancellation and Payment Policy

I understand that I will be charged and expected to pay a cancellation fee of $135 if I fail to cancel an appointment at least 24 hours in advance of the appointment time. I understand that with the exception of Worker's Compensation and Medicare, payment is due in full at the time of service. I understand that it is my responsibility to collect reimbursement from my private insurance company using the superbill provided if I so desire.

Signature _____ Date _____