South Valley Physical Therapy

For Office Use Only	
Acct#	______________
Diag/ICD 9	______________
Therapist	______________
Ins. Code	______________

PATIENT INFORMATION

Today's Date:_______________________

Name____________________________________ Age _____ Birthdate ________________

Address____City__________State____Zip_______

Home ph________________ Cell ph ________________email_____________________________

Referring MD_________________________ Date injury/onset/surgery________ Body Part___________

Employer_______________________________________ Work ph_______________________

Primary Care Physician____

Is there someone we should thank for referring you?___________________________________
MD Friend Family Member

EMERGENCY INFO: Who should we contact in case of emergency?

Name_________________________________ Phone________________ Relationship____________

PRIMARY INSURANCE INFO:

Insurance company__________________________ Group#___________ ID#________________

Policy Holder____________________________________ Relationship____________________

Insured's Birthdate ___________________ Employer_________________________________

SECONDARY INSURANCE INFO: (if applicable)

Insurance Co_______________________________ Policy Holder___________________________

DOB___________Relationship________________Group#________ID#________________________

WORKERS COMP INFO: (if applicable)

Insurance Carrier___________________________ Adjuster__________________________________

Claim#_______________________ Phone#________________ Fax_____________________

For Office Use Only:
Notes____
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South Valley Physical Therapy

Policy on Cancels and "No Shows"

Physical therapy is an on-going process which requires regular attendance to be effective. If you do not attend your scheduled sessions, you may be hindering your progress. If you must cancel, please call more than 12 hours ahead of the appointment time. If you fail to cancel and do not show up for the appointment, we count that as a "No Show". We document each "No Show". If two "No Shows" occur, in a row, your physician and insurance company will be notified of your failure to attend scheduled appointments. This may have some effect on your worker's compensation status or your disability benefits. Also, you will be charged **$25.00 for each NO SHOW AND $15.00 FOR CANCELLING WITH LESS THAN 12 HOURS NOTICE**

If you have reason to believe you are contagiously ill, (cold, flu, etc...) please let us know, we have facial masks for you to wear to avoid our exposure.

Signature___________________________________ Date__________________________________

Privacy Act

South Valley Physical Therapy is a HIPPA Compliant Practice

I have read and fully understand South Valley Physical Therapy's Notice of Information Practices (on clipboard) I understand that South Valley Physical Therapy may use or disclose my personal health information for the purposes of **carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment**. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that South Valley Physical Therapy, Inc will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted above. I understand that I retain the right to revoke this consent by notifying South Valley Physical Therapy in writing at any time. **If you would like a copy of our privacy act for your records please ask at the front desk.**

____ _______________________________

Patient Name (print) Signature

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Date