Forefront
PHYSICAL THERAPY

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Physical Therapy Patient Information Form

v3

Date: _____ / _____ / _____

Patient Information

Name (first, middle, last): _____ | _____ | _____

Gender: ☐ Female ☐ Male ☐ Other: _____ Date of birth: _____ / _____ / _____

Address

Street: _____ City and State/Province: _____

Zip/Postal Code: _____ Country (If outside of US): _____

Contact

Home phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Email: _____ @ _____

Preferred Contact Method: ☐ Email ☐ Home phone ☐ Cell phone ☐ Work phone

Emergency Contact

Relationship: ☐ Spouse ☐ Parent ☐ Other: _____

Contact Name (first, last): _____ | _____

Contact phone: (_____) _____ Email: _____ @ _____

Release of Medical Records

I authorize the release of my medical records to the following health care providers/insurance company:

_____

Acknowledgement of Patient Responsibilities

☐ I certify that the above information is true and correct to the best of my knowledge.
☐ I understand that there will be a $75 charge for missed appointments or late cancellations of less than 24 hours.
☐ I acknowledge that I have reviewed and been offered copies of the clinic's privacy notice and policies.
☐ I understand that by signing this form I am accepting financial responsibility as explained for all payment for products and services received. I understand my financial responsibility as a patient.
☐ I understand that it is my responsibility to obtain any pre-authorization that is necessary to get an estimate of my beneits from my insurance company.
☐ I understand that my therapist will provide me with a receipt that is my responsibility to submit to my insurance company.

Signature: _____ Date:_____