Forefront PHYSICAL THERAPY

Leigh Hollowell, PT, MS
6526 Dana St., Oakland CA 94609
Voice 510-228-0703 • Fax 415-874-1966
info@forefrontphysicaltherapy.com

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Physical Therapy Patient Information Form

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

Health care providers/insurance company to which you consent to release your physical therapy records:

____

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:_________________