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**Optimal Physical Therapy**

**&**

**Industrial Rehabilitation, Inc.**

**PATIENT REGISTRATION**

Patient Name**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name M.I.

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Widowed Divorced/Separated

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street or P.O. Box City State Zip Code

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If Different than above)** Street or P.O. Box City State Zip Code

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_

**APPOINTMENT REMINDER PREFERNCE:** E-Mail Text

**INSURANCE POLICY HOLDER** *(Complete if different than patient)*

Name**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name M.I.

Social Security #: \_\_\_-\_\_\_-\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street or P.O. Box City State Zip Code

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If Different than above)** Street or P.O. Box City State Zip Code

**Did you sustain your injury at work?** Yes No **Are your injuries accident related?** Yes No

At OPT, we use a variety of procedures and modalities to help us try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain, injury or may aggravate existing conditions. You have the right to decline any portion of your treatment at any time before or during your treatment session.

**I acknowledge that my treatment program will be explained by my therapist at OPT, and all of my questions will be answered to the best of their ability. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (Patient Signature-Parent Signature if under 18) (Date)

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**&**

**Industrial Rehabilitation, Inc.**

**Release of Information and Assignment**

* I hereby authorize you to release to my referring physician and/or family doctor any information including the diagnosis and records of any treatment or examination rendered to me.
* I certify that the information I have reported with regard to my insurance coverage is correct. I hereby assign my insurance benefits to be paid directly to Optimal Physical Therapy for services rendered. I acknowledge that I am financially responsible for all non-covered services, deductibles, and copayments. I also authorize Optimal Physical Therapy to release any information required to process this claim.
* This authorization may be revoked by either my insurance carrier or me at any time in writing. I understand that my insurance coverage is a contract between the insurance company and myself and that Optimal Physical Therapy will submit claims on my behalf, but will not be responsible for filing appeals or disputing rejections. I authorize and understand that the office will be billing electronically. A copy of this authorization may be used in place of the original.
* I will be held responsible for all of the following if they accrue: collection fees, court costs and/or legal fees and a $35.00 fee for all returned checks.

**Cancellation/No Show Policy**

* We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment at least 24 hours prior to the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.
* To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than 24 hours notice. Late cancellations will be treated as a “no-show” per our office policy.
* If a patient is 15 minutes past their scheduled time, we may have to reschedule their appointment.

**The following charge is effective as of January 1, 2021:**

* Patients will automatically be charged a **$70** “no-show” or late cancellation/reschedule fee. This fee must be paid before services can be rendered for following scheduled visits.

**My signature below certifies that I have read, understand and agree to the terms above.**

**Patient Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**