Patient Information

Please fill out completely. Thank you.

Name: Last_____ First_____Age___

Date of Birth___/___/____ M__F__ SS#_____

Mailing Address_____City_____State____Zip_____

Physical Address_____City_____State____Zip_____

Home Phone_____/_____/_____Cell____/_____/_____Work Phone_____/_____/_____

Referring Physician:_____: Occupation _____

Employer_____Employer's Phone #_____

Employer Address (Work Comp Only)_____

Emergency Contact_____Phone_____/_____/_____

Relationship to Patient:_____

***Preferred method of appt reminders: Text Message or Voice call (circle one)

Insurance Company:_____

Relationship to Insured: Self Spouse Mother Father Guardian

Name of Insured:_____DOB:_____

Date of Injury: _____

Was This Work Related?_____Auto Accident? _____Other?_____

If so, Claim #_____

Insurance Company Name:_____

Claims Adjuster's Name:_____

Claims Adjuster's Phone #:_____

Waitlist/Cancellation Policy

Rivergate Physical Therapy has a waitlist. If you ever need to cancel an appt please call us 24 hours before your appointment so we can try to fill your time slot. Cancellations that are made with less than 24 hours notice are subject to a $25 cancellation fee.

Signature_____

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Informed Consent:

I consent to and authorize Rivergate Physical Therapy, PC, to administer all treatments and services that may be considered advisable in the judgment of my physician and/or therapist, in accordance with their policies. If I fail to sign the consent, treatment will not be provided.

Signature of Patient (or Guardian) _____

Date: _____

Consent for Use of Healthcare Information for Purposes of Payment and Healthcare Operations

I consent to the release of, and use by, or disclosure of my protected health information to and by Rivergate Physical Therapy, PC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations at this clinic.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed, to carry out treatment, payment, or healthcare operations at the practice. Any and all protected information may be disclosed to at any time to the following persons.

_____ _____

Authorized Person / Relationship to Patient Authorized Person / Relationship to Patient

Signature of Patient (or Guardian) _____

Date: _____

Acknowledgement of Receipt of Privacy Practice

I understand and have reviewed Rivergate Physical Therapy's, PC, Notice of Privacy Practices. The notice of Privacy Practices describes the types, uses and disclosures of my protected health information that will occur during my treatment, payment of my bills, and in the performance of the healthcare operations of this clinic.

Signature of Patient (or Guardian) _____

Date: _____