Twin Lakes
PHYSICAL THERAPY

Name of Patient: ______________________________________ Date of Birth: _____________ SS#: _________________________

Name of Guardian (if under 18 years of age): _______________________________________ Sex: ☐ **M** ☐ **F**

Address: ____ Home Phone:________________________

City: ______________________________ State: _________ Zip: ____________ Cell Phone:__________________________

Employer: ____ Work Phone:_________________________

Spouse Name: ______________________________ Spouse SS#:_________________ Spouse Cell Phone:___________________

Spouse Employer: ___________________________ Spouse Date of Birth:__________ Spouse Work Phone:__________________

Email Address: ____ Email Appointment Reminders: ☐ **YES** ☐ **NO**

Receive Text Message Appointment Reminders: ☐ **YES** ☐ **NO** Cell Phone Provider (e.g.Verizon):______________________

IN CASE OF EMERGENCY:
Name:________________________________ Phone #:_________________________ Relationship:____________________________

Authorization to Pay Insurance Benefits: I hereby authorize my insurance company to make payments directly to Twin Lakes Physical Therapy for their services specified and otherwise payable to me but not to exceed the Physical Therapist's regular charges for this/these procedures. **I agree and understand that I am responsible for any deductibles, coinsurance, and co-pays and I am financially responsible to Twin Lakes Physical Therapy for charges not covered by this authorization.**

Consent to Treat: I hereby consent to skilled physical therapy treatment that has been ordered by my referring physician and/or found reasonable and necessary by the Physical Therapist. I understand I have a choice of where to receive my therapy and I am choosing Twin Lakes Physical Therapy to render my treatment. I certify that my insurance information is correct. I agree to be totally responsible for services rendered by Twin Lakes Physical Therapy if any information provided is incorrect or if claims are denied by private insurance.

Please initial below:
_______ I understand that I can receive a copy of the Notice of Privacy Practices discussing uses and disclosures of your medical information and can review them with a staff member of Twin Lakes Physical Therapy upon request.

Patient Signature: ____ **Date:**__________________

Signature of Guardian / Relationship: ____ **Date:**__________________

Self-Referred Authorization: If you are referring yourself to physical therapy without a physician's referral, a physical therapy diagnosis is **NOT** a medical diagnosis by a physician or based on radiological imaging, and that such services might **NOT** be covered by the patient's health plan or insurer.

Patient Signature: ____ **Date:**__________________