

# 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): \_\_\_\_\_

<p><b>IN CASE OF EMERGENCY:</b> Name: _____ Phone #: _____ Relationship: _____</p>
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**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.

\_\_\_\_\_ I understand that in order to protect the privacy and safety of all patients, at no point will any photography, video recording, or cell phone use be allowed in the treatment area.

\_\_\_\_\_ I understand that by opting into text message reminders, messaging or data rates may apply to messages sent to my cell phone. I know that I am under no obligation to authorize Twin Lakes Physical Therapy to send me appointment reminders by text or email. I also understand that I may opt-out of receiving appointment reminders at any time by calling Twin Lakes Physical therapy at 478-452-6252.

**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:** \_\_\_\_\_