



**Patient Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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

Social Security # \_\_\_\_\_ D.O.B. \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician/Party: \_\_\_\_\_

I authorize Michele Kreisberg Palmer to provide my physical therapy services. I have read and understood the patient privacy policy (HIPPA) and will sign an authorization to use or disclose my health information when necessary. Initial \_\_\_\_\_

**Insurance Information**

Insurance Carrier \_\_\_\_\_

ID# \_\_\_\_\_

Group # \_\_\_\_\_

If insured under spouse:

Spouse Name \_\_\_\_\_

Address \_\_\_\_\_

D.O.B. \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

I have had previous physical therapy visits this year? Yes \_\_\_ No \_\_\_

If yes, how many visits \_\_\_

**Cancellation Policy**

I agree to provide a 24-hour notice of cancellation for scheduled appointments or else a full session fee will be charged. Initial \_\_\_\_\_

Payment arrangements must be discussed and made in writing prior to the initiation of treatment. Initial \_\_\_\_\_

Fee for Service rates are \$125 per hour. Otherwise, I agree to have my Insurance Carrier billed for all physical therapy services provided, and agree to pay for all uncovered expenses, co-pays and patient portions as allowed by my insurance policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_