



Name: _____ Date of Birth: _____

Email Address: _____ Social Security Number: _____

Is this a Liability case, work related injury or injury due to a Motor Vehicle Accident? Yes / No

Please let us know if the address on your identification is not current.

Cancellation Policy

Missing an appointment hinders your recovery and disrupts the schedule of your therapist. In the case that you need to cancel or reschedule please call at least 24 hours before you appointment.

There will be a \$25 charge for missed follow up appointments, without 24 hour notice.

Financial Policy

We will do our utmost to assist in gathering information regarding claims, but it is your responsibility to know your benefit and coverage limits. Payment is due at the time of services for co-payments and services not covered by your insurance company. Unpaid balances will be referred to a collection agency.

Consent to Treat

The undersigned authorizes Performance Physical Therapy to complete a Physical Therapy evaluation and to administer treatment that is necessary and appropriate.

Acknowledgement of Terms

By signing below, I attest that all information I provide is true and correct. I have read, understood and accept the policies stated above.

Patient signature: _____ Date: _____

Patient Care Coordinator: _____ Date: _____

Notice of Privacy Practices

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

Patient Signature: _____ Date: _____

For office use only – in the case that acknowledgement not obtained.

Patient Refused Other _____

Signature and Date: _____

Thank you for Choosing Performance Physical Therapy!