DeWitt
PHYSICAL THERAPY

PATIENT INFORMATION SHEET

Please print in blue or black ink.

Patient's Legal Name _____Date_____
Preferred Name _____ Date of Birth _____
Parent or Guardian (if minor)_____
Social Security Number _____*for billing purposes only
Address _____City_____
State _____ Zip _____ Billing Address (if different)_____
May we email you appointment reminders? ***Yes*** *or* ***No*** Email_____
Primary Contact (circle one) Home Cell Work Home Phone_____
Cell Phone _____ Work Phone _____
Emergency Contact Name _____ Relation _____ Phone _____

Referring Medical Provider_____
Do you authorize DeWitt Physical Therapy to discuss your treatment with your referring doctor? Yes No
What injury or condition are you seeking treatment for?_____
Date of Onset _____ Date of Surgery_____

Primary Insurance_____
Primary Subscriber _____Date of Birth _____

Secondary Insurance_____
Primary Subscriber _____Date of Birth _____

Is Injury Work Related? ____Reported to Employer? ____If yes, is your case still active? ___

PATIENT'S SIGNATURE _____**DATE** _____
Notice to All Patients: *You are responsible for your balance accrued at DeWitt Physical Therapy regardless of insurance coverage.*

CANCELLATION POLICY

We require at least a 24-hour notice if you need to cancel your appointment. Cancellations with less than a 24-hour notice will be charged a $35.00 "Late Cancel" fee. In the event of a missed appointment without cancellation notice, you will be charged a "No Show" fee of $85; the price of a full treatment visit. Appointments cancelled less than 2 hours prior to your scheduled time will be considered a missed appointment a "No Show" fee.

If you are ill, we kindly request that you cancel your appointment with a 24-hour notice. Your rehabilitation is very important to us, but we appreciate your consideration of other patients in the process of healing and our staff trying to provide superior care.

At the discretion of the front office staff and your physical therapist, you will be asked to seek treatment elsewhere if you demonstrate a history of chronic of absenteeism.

I have read and understand DeWitt PT's cancellation policy. Initial here _____

CONSENT FOR TREATMENT

I have been informed by DeWitt Physical Therapy of the treatment and care which has been prescribed by my physician(s) and will be provided by DeWitt Physical Therapy. I understand as a patient, I am under the care and control of my physician(s) and that DeWitt Physical Therapy is not liable for any act or omission when providing treatment in accordance with my physician's instructions.

I acknowledge that no guarantee or assurance has been, nor can be, made by DeWitt Physical Therapy as to the result of the prescribed treatment. By signing this agreement, I consent to have DeWitt Physical Therapy provide the treatment and care prescribed by my physician. I understand this consent may be revoked by me at any time.

PATIENT'S SIGNATURE _____ **DATE** _____
If patient is a minor, must be signed by a parent or legal guardian.