Valley Physical Therapy

Legal Name_____ Nick Name_____

Mailing Address _____City_____Zip_____

Street Address (if different) _____

( ) _____Cell / Home ( ) _____C / H Email _____

Date of Birth_____ Social Security #_____ Driver's License#_____

Emergency (name, phone # & relation) _____

Your Occupation_____

Employer _____ Phone ( ) _____

Physician treating this condition_____ Phone ( ) _____

Address_____

Would you like reminders of appointments via email? □ Yes □ No (if yes please provide email above)

Would you like reminders of appointments via text? □ Yes □ No (if yes please provide cell # above)

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I will be billing this claim through my (circle one):

Private Ins. (i.e. Blue Cross, Blue Shield, Aetna, etc.) **Medicare** **Worker's Compensation**

Auto Insurance **Other**

Name of insured if other than yourself (Guarantor) _____

Guarantor's SS# _____ Guarantor's Date of Birth _____

Relationship to you: **Spouse** **Parent** **Child** **Other**

Guarantor's Address if different than yours:

Street _____

City _____ State _____ Zip _____

Please provide us with your insurance cards so we may make a copy

(Please turn me over)

Valley Physical Therapy

Legal Name_____ **Date** _____

Please read and initial each of the following statements

Initials

_____ I understand that I have been referred to physical therapy for treatment and that this treatment may involve exercises, instruction in movements, manual techniques (the therapist using hand contact), as well as applications of heat, cold, electrical current or other modality of treatment. I understand that no guarantee or assurance has been, nor can be made by Valley Physical Therapy as to the results of the prescribed treatment and that my complete participation is required for optimal results to occur. I understand I am encouraged to ask questions as they arise.

_____ The State of California requires you have a diagnosis from a physician before you can receive physical therapy treatment. A physical therapist can evaluate you without a diagnosis from a physician, however, cannot provide treatment.

_____ I understand that I am personally responsible for all charges incurred by me or my dependant at Valley Physical Therapy.

_____ I have received the Notice of Privacy Practices from Valley Physical Therapy, Inc.

_____ I give Valley Physical Therapy the permission to leave a message on my answering machine

_____ I give permission to discuss my medical condition with another person (other than referring MD):

Whom? _____ Relationship: _____

_____ **I understand that a $40 fee will be charged directly to my credit card on file for appointments canceled with less than 24 hour notification.** ***(Chronic no shows and late cancellations will be dealt with on a case-by-case basis and may result in you no longer being able to receive services at our office.)***

I certify that the above information is true and correct to the best of my knowledge. I will inform Valley Physical Therapy of any changes in this information if it should occur during the course of my treatment.

Signature_____ Date_____