DuPont Physical Therapy

Patient information

Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (_____) _____-_____Cell (_____) _____-_____ Work (____) _____- _____

Date of Birth ____/____/_____ SSN _____ Gender _____ Marital Status _____

How did you hear about us? (check the box that best applies) ❒ Referred by Doctor ❒ Saw Advertisement ❒ Past Patient ❒ Recommended by family/friend ❒ Internet Search (Google) ❒ Social Media (Facebook)

Emergency Contact

Last Name _____ First Name _____

Relationship_____ Phone(_____)_____ _____

Employer

Name _____ Phone(_____)_____ _____

Mailing Address _____

City _____ State _____ Zip _____

Authorization to treat, release information and assignment of insurance benefits

I hereby authorize DuPont Physical Therapy to evaluate and treat me (or my dependent). I authorize DuPont Physical Therapy to release to my insurance company(ies) any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at DuPont Physical Therapy. I hereby agree to full responsibility for all expenses incurred by myself, or minor child.

Financial policy and agreement

1. Insurance co-payments are required at check-in. We accept most major credit cards, cash and check.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does or does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company.

Notice of privacy practices acknowledgement (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

Other parties whom you would like to receive information on your behalf (not insurance companies):

_____

No-show/Late cancellation policy

At DuPont Physical Therapy, we value our time with our patients and believe that keeping your appointment is an integral portion of your recovery. **Please be advised, a minimum of 24 hours' notice is required if you need to cancel an appointment.** If you no-show or cancel without sufficient notice twice, you will be placed on a same-day call in basis. This means you will have to call in the morning for an appointment that day. We may not be able to accommodate all same-day call in requests.

Message authorization

I authorize DPT to leave detailed information on my phone: Cell: Y / N Home: Y / N

Initials: _____

I have read and acknowledge the above statements with my signature below.

Signature: _____ Date: _____