S.O.A.R. Physical Therapy
CONFIDENTIAL

PATIENT INFORMATION					
Last Name:	First Name:	M.I.	Age:	Date of Birth:	Social Security:

Mailing Address:	Email Address (if any):	Sex: M F	Marital Status: S M D W O

City:	State:	Zip Code:	Cell Phone:	Home Phone:	Work Phone:

Emergency Contact Information:	Check the box if a message can be left on contact number: ☐
Emergency Contact Name:	Name of Referring Doctor:
Contact Number: / Relationship to Patient:	Name of Referring Clinic:

INSURANCE INFORMATION		
Primary Insurance:	Policy No.:	Subscriber Name:

NOTE: If Subscriber Name is other than SELF, please complete the following for the SUBSCRIBER information:

Relationship to Patient:	Social Security No.:	Date of Birth:	Contact Numbers:	Mailing Address:

WORKERS COMPENSATION INFORMATION (If Applicable)			
Employer:	Employer Address:		Employer Phone:
Supervisor Name:		Supervisor Phone:	
☐ Work Injury	☐ Auto Accident: Please indicate Place (State): _____	☐ Other: _____	Date of Injury:

ATTORNEY INFORMATION (If Applicable)		
Attorney's Name	Address:	Phone Number:

PLEASE READ CAREFULLY

Responsibility for payment:
The above is correct to the best of my knowledge. As a patient I understand that all charges for services rendered will be billed to my insurance carrier. If all or part of these charges are not paid by my insurance company, I will personally be responsible for any balance due (Workers Compensation excluded by law). I also understand that I will be responsible for ALL S.O.A.R. Inc's collection costs including Collection Company fees and attorney fees.

S.O.A.R. Inc does not and cannot accept patients with ***MEDICARE*** or ***MEDICAID*** even if wish to pay cash. S.O.A.R. Inc is not an enrolled provider currently.

Forms of payment:
VISA, Mastercard, Check* or Cash. *There is a *$30.00* fee for returned checks.

Authorization to Release Information:
I authorize the release of any information necessary to process my claim. I also authorize payment of medical benefits directly to the above medical provider, and/or its representative.

Patient's Signature / Parent or Guardian Signature (if minor) Date:

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APPOINTMENT POLICY

SCHEDULING APPOINTMENTS

We schedule appointments on a weekly basis. Therefore, if your treatment requires multiple visits, you must coordinate every appointment after each visit until treatment is completed to ensure that you are scheduled at the consistency that your treatment was ordered. We will provide you a list of your scheduled appointments. We may provide a reminder call for FOLLOW-UP visits.

LATE ARRIVALS

As a courtesy to other patients, we ask that you arrive on time for your scheduled appointment. Though we understand circumstances do arise, we cannot guarantee you will be seen if you are late more than **15 minutes**. You may have to reschedule your appointment.

CANCELLING APPOINTMENTS

Appointments must be cancelled 24-hours prior to scheduled appointment time.
NOTE: If you do not notify us **24-hours** in advance or missed your appointment, you will be charged a penalty of **$25.00**.

MISSED APPOINTMENTS

If you miss **two (2)** or more appointments without notifying us, we will remove your name from the schedule.

We will:
1. Notify the agency that is responsible for your case (i.e. Worker's Comp., attorney, insurance agency, etc.)
2. Notify the referring physician and recommend discharge or termination of treatment until further notice.

MEDICAL RECORDS

We maintain records for 7 years after end of treatment. We require a minimum of 3 days advance notice to obtain a copy of your medical records and there will be a charge of **$35.00**.

I acknowledge that I have read and understand the appointment policy.

Signature: ______________________________ Date: ______________________________

* *

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________ , have received the Notice of Privacy Practices (NPP)
Print Name *(Parent's name if patient is a minor)*

from Sport's, Orthopedics & Active Rehabilitation, Inc (S.O.A.R Physical Therapy). In the event of a patient information breach, patient will be notified.

Signature: ______________________________ Date: ______________________________

* *

Parent Consent for Minors

I, ______________________________ , give permission to S.O.A.R. Physical Therapy to provide
Print Name *(Parent's name if patient is a minor)*

treatment for my daughter/son ______________________________ without my presence.
Print Name *(of the minor)*

Signature: ______________________________ Date: ______________________________