S.O.A.R. Physical Therapy

CONFIDENTIAL PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Sex M F	Marital Status: S M D W
Mailing Address:			Social Security No.		Cell Phone
City	State & Zip Code		Home Phone		Work Phone
Email Address (if any):			Emergency Contact Name		
Name of Referring Physician & Clinic			Emergency Contact Phone		Emergency Contact (Relationship to patient)
Employer, If Workers Comp:			Supervisor		Phone
Employer Address			State	Zip Code	Phone
☐ Work Injury ☐ Auto Accident : Please indicate Place (State) _____ ☐ Other					Date of Injury:

INSURANCE INFORMATION

Primary Insurance	Policy No	Subcriber Name

Note: If Subscriber Name is other than SELF, please complete the following:

Subcriber's Soc. Sec. No.		Subscriber's Mailing Address:	
Subscriber's DOB	Home No.	Work No.	Relationship to Patient

ADDITIONAL INSURANCE (IF ANY)

Secondary Insurance	Policy No	Subscriber Name

Note: If Subscriber Name is other than SELF, please complete the following:

Subscriber's Soc.Sec. No.		Subscriber's Mailing Address:	
Subscriber's DOB	Home No.	Work No.	Relationship to Patient

ATTORNEY INFORMATION (IF APPLICABLE)

Attorney's Name	Address	Phone No.

Please Read Carefully

Responsibility for payment:
The above information 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 parts 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 of SOAR Inc.'s collection cost including Collection Company fees and attorney fees.

We do not and cannot accept patients with **MEDICARE** *or* **MEDICAID** *even if you wish to pay cash. S.O.A.R. Inc. is not an enrolled provider at this time.*

Forms of payment: Visa, Mastercard, Check or Cash. There is a $25.00 fee for checks returned.

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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Sports. Orthopedics. & Active Rehabilitation.

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 do not provide reminder calls for **FOLLOW-UP** visits.

CANCELLING/ LATE APPOINTMENTS

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

MISSED APPOINTMENTS

If you miss **two (2) consecutive** 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 the 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** from
Print Name (Parent's name if patient is a minor)

Sports, Orthopedics & Active Rehabilitation, Inc. 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 or Guardian name)

treatment for my daughter/son ____ without my presence.
Print Name (Daughter or Son's name)

Parent or Guardian Signature: _____________________________________ Date: ___________________