Name: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle\_\_\_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Phone# Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*With my consent, Buena Vista Physical Therapy LLC may call or LM for me at the numbers marked above. \_\_\_\_\_\_\_\_initials\*\**

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation/Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male or Female Primary Care Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider/MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Divorced Widowed Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (name & phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Information**

Insurance CO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (relationship) myself spouse parent

The policy indicated above is a: Commercial Employer-Group Auto Ins Workman Comp

 *We will call your insurance company and communicate your therapy benefits to you*.

Informed Consent: I consent to and authorize Buena Vista Physical Therapy, LLC to administer all applicable treatments and services that may be considered advisable in the judgment of my physician and/or therapist in accordance with physical therapy standards. This includes authorization of all insurance benefits to be paid directly to Buena Vista Physical Therapy, LLC.

By signing, I am allowing Buena Vista Physical Therapy, LLC the use and disclosure of my protected health information (PHI) to carry-out treatment and/or payment. I allow Buena Vista Physical Therapy to communicate with my PCP and/or referring provider. I may revoke this consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent.

Please list who we may release your medical information to:(family~medical professionals~lawyer~employer)

1. 2. 3.

**Cancellation Policy**: The policy of BV PT is to charge a $25.00 cancellation fee for scheduled appts not attended or cancelled within 24 hrs. You will be required to pay this fee at your next appointment. Please call ASAP to reschedule any appointments and to avoid incurring a fee. \**After 3 missed appointments you will be charged $75.00-full price for a physical therapy visit.*\*

**I understand I am financially responsible for all non-covered services, my deductible and any copay/coinsurance amounts.**

Signature of Patient/Guardian: Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**How did you hear about us? Doctor Friend Radio Yellow Pages Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

~If I choose not to not sign, Buena Vista Physical Therapy, LLC may decline to provide services to me.~