Acker Physical Therapy
& Neurological Rehabilitation

Patient Information

Name_____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Phone (H) _____ (W) _____(C) _____

E-Mail Address _____

Can we communicate to you by: E-Mail ____ Texting ____

Referring Doctor Name _____ Phone _____

Primary Care Physician _____ Phone_____

Medication List

Name of Medication	Dosage

Height _____Weight _____ Allergies_____
Chief Complaint / Diagnosis _____
Date of incident _____
How has this affected your daily activities?
_____
_____

Have you received Home Health Care? YES/NO If so, what were the dates?
_____
_____

Have you received therapy for this issue in the past?
(circle) PHYSICAL/ OCCUPATIONAL/ SPEECH, if so, where and when did you receive these services?
_____
_____

Insurance Information

Relationship to Insured: Self _ Spouse __ Child __ Other __

If other, please explain _____

Primary Policy Holder Name _____ Date of Birth _____

Insurance Company _____
Member/Subscriber ID _____
Phone Number for PROVIDER SERVICES (on back of card) _____

Secondary Policy Holder Name _____ Date of Birth____/____/_____

Insurance Company _____

Member/Subscriber ID _____

Phone Number for PROVIDER SERVICES (on back of card) _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I am also responsible for payment of non-covered services.

Signature _____Date _____

EMERGENCY CONTACT INFORMATION

1. Name _____

Relationship _____ Phone number _____

PAYMENTS

We will be collecting copays and coinsurance amounts upon check in. Co-insurance is the amount the insurance company does not cover. Please check with your insurance company for your copay/ coinsurance amounts. If necessary, we can discuss payment plan options with you at your next appointment. If your account ends up in collection, you will be charged a 35% collection fee.

REMINDERS

WE ARE NOT IN NETWORK WITH MEDICAID AND YOU MAY BE HELD RESPONSIBLE FOR ANY CHARGES INCURRED

Due to the increasing number of last-minute cancellations and late arrivals, effective immediately we will be implementing the following policy.

LATE ARRIVAL, CANCELLATION & NO-SHOW POLICY

There will be a **$25.00** charge for **any un-cancelled appointments (NO SHOW)**. Please make sure that you cancel your appointments that you are not able to attend within 24 hours if possible. We do understand that a 24 notification is not always possible. If a 24-hour timeframe cannot be met, we will be glad to discuss the situation with you. Please be aware and considerate of our waitlist and schedules.

Likewise, if you have **3 called-in cancellations in 1 month**, this will result in a **$25.00** charge being billed to you.

You may reach our office on 803-708-3950. If you do not reach a person, please leave a message that you are cancelling. Unless alternate appointment times are discussed, we will see you at your next scheduled appointment time.

Patient Name (print): _____

Patient Signature: _____ Date: _____