ACTIVE MOTION
PHYSICAL THERAPY

New Patient
Returning Patient

Date of 1st appt:
Time of 1st appt:
Therapist:
Scheduled by:

Patient Name (Mr., Ms., Dr.) _____ Preferred Name: _____

Address: _____City: _____ Zip:_____

Date of Birth:_____ Email Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Referring Doctor:_____Therapist:_____

Injured Area:_____ Date of injury or surgery:_____

Emergency Contact:_____ Phone#:_____ Relationship_____

How did you hear about us?:_____

Do you have a Do Not Resuscitate order? _____ If so, please provide us with a copy of the document.

Insurance Information:

Have you used home health care for the current issue?_____ Have you officially been discharged?_____

Injury due to: Work/Work Comp:___ Auto Accident:___ Other:___ Adjuster:_____

Responsible Party: Self:___ Spouse:___ Parent:___ Guardian:___ Other:_____

Primary Insurance:_____ **Insurance Phone** #:_____

Claim/ Policy #:_____ Group#:_____

Secondary Insurance:_____ **Insurance Phone#**:_____

Policy#:_____ Group#:_____

Insured's Name (if not self):_____ Insured's Date of Birth:_____

Patient Initials:

Consent to treat: I authorize Active Motion Physical therapy to render services as deemed necessary for the care of the above named patient.

Medical Release of Information: I authorize Active Motion Physical Therapy to release medical information and/or contact my Doctor or Attorney as necessary to process a claim.
Attorney's Name if applicable:_____ _____

Assignment of Benefits: I understand I am financially responsible for any charges not covered by my insurance. I hereby assign payment directly to Active Motion Physical Therapy for the basic benefits as well as major benefits otherwise payable to me, for charges related to this treatment. I understand I will be held responsible for any cost incurred regarding collection of payment for services rendered.

Cancellation Policy: If you are unable to attend you scheduled appointment, we require at least 24-hour notice. **No-shows or last minute cancellations will result in a $50.00 charge.** This is not covered by your insurance policy and will be your responsibility. Illness and emergencies are, of course, exceptions to this policy. _____

Patient Signature:_____ **Date:**_____