36397 N Gantzel Rd Suite 102
San Tan Valley, AZ 85140
P: 480-567-2987 F: 480-347-0240 Date:______________________

Patient Information:

Name (Last, First, Middle):____
Date of Birth: _________________________ Age: _________ SS #: _______________________
Address: _____________________________________ City: ________________ State: ____ Zip: ________
Home Phone: __________________ Cell: _________________ Email: ______________________________
Referring Physician: _______________________________Phone: _____________________
When is your next doctor follow up visit: ____
Emergency Contact: ______________________________Phone:________________Relationship:___________

Primary Insurance:

Patient relationship to policy holder: Self Spouse Child Other___________________
Insurance Company: ___________________________ ID#____________________ Group#________________
Policy Holder: ___________________________ DOB__________ Policy Holder Employer:_________________
Employment Status: Full Time Part Time Retired Unemployed

Secondary Insurance:

Patient relationship to policy holder: Self Spouse Child Other___________________
Insurance Company: ___________________________ ID#____________________ Group#________________
Policy Holder: ___________________________ DOB__________ Policy Holder Employer:_________________
Employment Status: Full Time Part Time Retired Unemployed

Workman's Comp or MVA:

Date of Injury: ____________ Claim#______________________ Contact Person:_____________________
Contact Phone and Address: ____
Claims Address: ____

Additional Information:

Is reason for Visit due to an Accident? No At Work At Home Automobile Other________________
Have you been seen by a Physical Therapist this calendar year? _______________________________________
Have you recently had home health physical therapy? ____

How did you learn of Inbalance PT? ____
What are you being seen for? ____
When did it begin? ____

Please Initial each section:

☐ Cancellation/Late Policy

If it becomes necessary for you to cancel or reschedule an appointment, please notify the office 24 hours in advance, when possible. We realize extenuating circumstances i.e. emergencies may occur. However, exceptions to this rule are made at the discretion of management. If repetitive cancellations and/or no shows occur, you may be charged a cancellation fee of $45.00 per occurrence. The cancellation fee will be the responsibility of the patient, as most insurance companies will not compensate our practice for cancelled appointments or no-shows. We appreciate your patronage and ask your cooperation in maintaining the Cancellation and No Show Policy. Thank you.

☐ Consent To Treat

I consent to rehabilitation and related services at Inbalance Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. In cases of minor children, I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

☐ Financial/Insurance Policy

I hereby assign all insurance benefits to Inbalance Physical Therapy for services performed as a result of my illness or injury.
Non-insured Patient: I agree that I am responsible for payment at the time of service, unless prior arrangements have been made.
Deductible / Coinsurance: I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible is met, my coinsurance amount will be collected at time of service.
Non-covered Procedure: I agree to pay for all non-covered services (preventative or routine) not paid by my insurance.
Collections: After having a balance on your account for 90 days and have not set up a payment plan with our billing department or paid in full you will be sent to a collections agency. Once an account is placed in collection status all future services must be paid in full at the time of service. I understand that there will also be a $25 returned check fee.

☐ Notice Of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected, and how I can get access to this information is available to me upon request.

☐ Release Of Medical Records

To complete my insurance claim and treatment, I authorize Inbalance Physical Therapy to release my medical records to my physician(s), clinic, Hospital, or insurance company (including government programs).

☐ Referral And Insurance

I understand that in the check in process, if I do not have my referral and/or insurance card I will be responsible for any payment rendered at the time of service. I understand that I am responsible to know if my insurance company requires pre-authorization for my treatment. I also understand that I can avoid this expense by bringing my referral and/or insurance card to my scheduled check in time or I understand that I can call my referring Doctor's office and have these items faxed to Inbalance Physical Therapy prior to my scheduled appointment.

☐ Treatment Precaution

It is possible that during the course of treatment here at Inbalance Physical Therapy, exacerbations (flare-ups) of conditions (known or unknown) may occur. Every attempt will be made to minimize such an occurrence and should one occur, appropriate action will be taken by the therapist.

☐ Additional Items

Cell Phones: We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.
Children: Children requiring supervision are not allowed to attend sessions with you.

By signing below I acknowledge that I have read, understand and agree to all of the above. I understand that if I have questions regarding the above policies that it is my responsibility to ask.

Patient/Parent/Guardian Signature:____ Date: ________________