Eagle Rock Physical Therapy Patient Registration

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Patients Name ______________________ Patient DOB______________ Sex__________

Mailing Address______________________Physical Address ______________________

City ______________State______________Zip______________________

Home Phone # ______________________ Cell Phone#______________________
May we leave a message Yes_____ No_____ Work Phone# ______________________

E-mail______________________How did you hear about us? ______________

Work Related Injury? Yes____ No_____ MVA Yes_____ No_____

Have you been treated at any other clinic for
Physical/Massage/Occupational/Speech Therapy this year? Yes_____ No_____

Insurance Name ________________ Policy Holder________________ DOB ________

Group Number (claim number if L&I)________________ Insurance Phone # ______________

Primary or Referring Physician________________ Physician Phone # ______________

Employer ______________________ Occupation ______________________

Emergency Contact

Name ________________ Phone ________________Relation________________

Under 18 Parental Consent

________________ ________________ ________________
Print Parent/ Guardian name Parent/ Guardian Signature Date

Please Read and Sign

As a patient of Eagle Rock Physical Therapy, I give permission to release medical information to my doctor and insurance company. I also agree to be financially responsible for the portion of my bill that the insurance company does not pay. I understand that it is my reasonability to inform any changes to my insurance coverage. I acknowledge Medicare only pays for 80% of total bill if applicable. I have been advised of my Notice of Privacy Practices (HIPPA).

Patient /Guardian Signature ________________ Date________________

Missed Appointment Policy

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *Eagle Rock Physical Therapy* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals, you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all you your appointments; however, should you need to cancel please note that we require a **24-hour notice.**

If you need to cancel please call our office and reschedule. If you do not cancel with a **24- hour notice** or if you do not show for an appointment **you will be charged $20** for the missed appointment.

If you miss 3 consecutive appointments, we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *Eagle Rock Physical Therapy* and we are looking forward to working with you and helping you reach your goals.

The Staff at Eagle Rock Physical Therapy

I have read and understand this policy.

_______________________________ _______________________________

Patient/Guardian Date