EPIC PHYSICAL THERAPY
HEALTH & PERFORMANCE

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PATIENT INFORMATION

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY, STATE, ZIP	
HOME PHONE	WORK PHONE	CELL PHONE
EMPLOYER	CITY, STATE, ZIP	EMPLOYER'S PHONE
MARITAL STATUS Single Married Divorced Widowed	GENDER Male Female	E-MAIL

INFORMATION OF RESPONSIBLE PERSON if different from the patient

NAME	DATE OF BIRTH	RELATIONSHIP TO THE PATIENT
ADDRESS	CITY, STATE, ZIP	
HOME PHONE	CELL PHONE	SOCIAL SECURITY NUMBER
EMPLOYER		EMPLOYER'S PHONE

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY		POLICY/ID NUMBER
NAME OF INSURED	RELATIONSHIP TO PATIENT	DATE OF BIRTH

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY		POLICY/ID NUMBER
NAME OF INSURED	RELATIONSHIP TO PATIENT	DATE OF BIRTH

FOR OFFICE USE ONLY: PLEASE PROCEED TO THE NEXT PAGE	
REFERRING PHYSICIAN:	DIAGNOSIS:

IS YOUR ILLNESS OR INJURY RELATED TO ANY OF THE FOLLOWING Please select ones		
□ AUTO ACCIDENT	□ EMPLOYMENT ACCIDENT	□ OTHER
DATE OF ACCIDENT OR INJURY	STATE OF ACCIDENT	

EMERGENCY CONTACT INFORMATION		
NAME	PHONE	RELATIONSHIP TO PATIENT

CONSENT TO TREATMENT

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to EPIC Physical Therapy. I am responsible for providing accurate insurance information and any balance due. I authorize EPIC Physical Therapy to release information to my insurance carriers concerning this treatment. I understand that if I do not pay for these services, my account may be sent to collections.

CANCELLATION AND NO SHOW POLICY

Please call to notify us if any situation arises that may prohibit your attendance. After three missed appointments and/or no-shows without notification, you will be removed from the schedule. Please call the clinic if you wish to continue treatment and you will be allowed to schedule the same day only. A no-show fee of 40.00 dollars will be applied to you on your next visit, not billable to your insurance.

I certify that I have read this form and understand its contents.

_____ _____

Signature of Patient or other Legally Authorized Person Date

All information provided to EPIC Physical Therapy will not be sold or used for marketing, study, and/or promotional purposes. The above information is solely used for facility information and billing purposes.

Statement of Privacy Notice

I acknowledge that I have been offered a copy of the privacy practices of EPIC Physical Therapy as required by the Health Insurance Portability and Accountability Act (HIPAA).

(Please let the front desk know if you wish to have/view a copy of our Privacy Practice)

Patient Name: _____

Patient Signature: _____

**If a patient cannot legally sign this acknowledgment, please indicate a reason why and complete the section below.*

Reason for other signer on Acknowledgement: _____

_____

Other Signer Name Signature

_____

Relationship to Patient Date Time

Authorization for Exchange of Medical Information

I, _____, hereby authorize the release of my medical information

to: (name) _____ who is my

(relationship) _____.

My rights: I understand I do not need to sign this authorization to receive health care benefits (treatment, payment of enrollment) from EPIC Physical Therapy). I may revoke this authorization in writing. To review the process of revoking this authorization, please read the Privacy Notice to patients where your disclosed information reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice

_____ _____

Patient /Guardian Signature Date

A copy of this acknowledgment must be retained electronically or in the patient's file and expires one year from date of signature.