



Authorization to Treat/Patient Information

Patient Name: _____ Gender: **M / F** Date of Birth: _____ Age: _____

Patient Address: _____ City: _____ Zip: _____

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

Email address (for appointment reminders): _____

Social Security No.: _____ Employer: _____

Occupation: _____ (if retired, what occupation are you retired from?) _____

Spouse/Parent Name: _____ Phone # _____

Primary Physician: _____ Referring Physician: _____

Are you vaccinated for COVID-19? (Yes) (No) If yes, do you have your booster? (Yes) (No)

Person to contact in case of emergency: Name: _____ Phone: _____

Please initial the following:

_____ I hereby assign all insurance benefits for services rendered to which I am entitled to be paid directly to Hughes Physical Therapy. I understand that if my insurance company/third party payer denies payment or makes partial payment, I am responsible for the balance.

_____ I hereby authorize the release of medical records to Hughes Physical Therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

_____ I understand that I am legally responsible for payment of all services rendered by Hughes Physical Therapy. If my insurance is being billed, I will be responsible for paying any deductible amounts. I understand that co-payments are due at the time of service. (Worker's Compensation patients will be responsible for the bill if claim is denied and private insurance has deductible/co-insurance/copy amounts or if they are uninsured).

_____ Due to the nature of our specialty and to assist with patient flow, we require a 24-hour advanced notice of appointment cancellations. If you fail to cancel or do not show for your appointment, we will assess a **\$20.00 fee**. You will be responsible for paying this fee as it cannot be billed to your insurance company. **Two (2) no-shows will result in cancellation of all remaining appointments and all future appointments will be scheduled on a day-to-day basis.**

_____ HIPPA: Hughes Physical Therapy will follow Federal Privacy laws. A copy of the Privacy Policy is available to me upon request.

_____ I hereby authorize Hughes Physical Therapy to provide treatment as prescribed by my physician.

_____ **Checks returned for non-sufficient funds (NSF) will be assessed a \$30 fee.**

Signature of Patient or Guardian: _____ Date: _____