900 Stanhope Gardens, Suite 101 Chesapeake, VA 23320
757.842.6562 Fax: 757.842.6563 www.RPTwellness.com

Restorative Physical Therapy & Wellness LLC

Patient Name:_____ DOB:_____

CLIENT INFORMATION
Address:_____ City:_____
State:_____ Zip:_____ Phone (H):_____(C):_____
Email:_____ SSN:_____
Emergency Contact:_____
Phone (H):_____ (C):_____
Primary Healthcare Provider:_____ Phone:_____

B – CURRENT HEALTH INFORMATION –
Primary complaint**:**_____
Addition concerns**:**_____

What would you like to focus on during your Wellness Visits? _____
_____

What are your goals for Wellness Visits? (circle all that apply)
Relaxation Maintenance Stress Reduction Other:_____

C – Health History
List and explain. Include dates and treatment received.
Medication (prescription, over-the-counter, supplementation):_____
_____
Surgeries:_____
_____
Injuries:_____
_____
Major/Minor Illnesses:_____
Current and Past Medical History (please list all diagnoses):_____
_____
_____
_____

Client Signature: _____ Date: _____

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Guardian Signature:_____ Date:_____

AUTHORIZATION FOR TREATMENT

I hereby authorize evaluation and treatment by Restorative Physical Therapy on behalf of myself and/or my minor children, including stepchildren.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or changes information as is necessary for third party reimbursement from any insurance payer or government agency involved in the payment of my treatment.

OBLIGATION OF PAYMENT

I direct and assign payment from my insurance company to Restorative Physical Therapy. I understand that I am ultimately responsible for payment of the entire bill for medical goods or services provided to my children or me and that my insurance policy is a contract between my insurance company and me. I shall pay any deductible and/or co-payment at the time of service. This amount is an estimate of the portion of the fee that is not covered by insurance.

I will advise Restorative Physical Therapy immediately of any changes in insurance coverage or my address.

If I am choosing to seek physical therapy from Restorative Physical Therapy as an out-of-network provider, I will be given the option to pay $75 flat fee, cash/credit/check payment. (Please see front desk staff regarding possible cash pay discounts.)

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

If payment from my insurance company is not received within 90 days, my account will be due and payable in full by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. If a self pay client (i.e. RPT does not take my insurance or my insurance benefits for P.T. are capped out for the year), I will pay the amount in full at time of appointment.

If prompt payment is not made, I understand that Restorative Physical Therapy may immediately take action to collect its charges and any outstanding balance. I agree to pay all costs and expenses incurred by Restorative Physical Therapy for collecting any amounts I owe, including court costs and thirty-three and one third percent attorney fees of any outstanding balance. Additionally, I understand that a fee of $25.00 will be applied to my account for any returned checks.

CELL PHONE USE POLICY

At Restorative Physical Therapy, our patients are at the center of everything we do. Among our many priorities, we value and respect the privacy of our patients, our visitors, and our staff. Patients and visitors are welcome to use personal devices in the lobby and outside the practice. No cell phone use is permitted in the treatment area or in treatment rooms. We appreciate your cooperation and ask you to follow them while at RPT.

Please be considerate of those around you when using your mobile devices. Remember that others may overhear your conversations and that you may not have an expectation of privacy. Use low, quiet voices, and do not act in a disruptive or disrespectful manner.

ACKNOWLEDGEMENTS

I, the Patient/Guardian, acknowledge that I was given an opportunity to ask questions about the information provided in this form. My signature is acknowledgment of my understanding of and agreement with the provision of this agreement.

Patient/Guarantor signature: _____ Date: _____

Patient/Guarantor print name: _____

Witness signature: _____ Date: _____

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Attendance Policy

Dear Valued Patient:

Please be aware of the following attendance policy created to best serve you and all of our patients. We look forward to providing quality care for you, and to aid in maximizing benefits from therapy, we need your full participation.

1. Please arrive on time for your scheduled appointment. Please call if you will be more than 10 minutes late. If you are more than **15 minutes** late for your appointment, we may be required to reschedule.
2. Please call 24 hours in advance if you know you have to cancel an appointment. We understand emergencies do happen, so in these instances please call as soon as possible to cancel your appointment.
   Restorative Physical Therapy reserves the right to assess a $50.00 service fee for cancellations with less than 24 hours notification and a $50.00 service fee to all no shows to our office.
3. We will have to remove you from our schedule after 3 consecutive cancellations or 2 "no-shows." This may require you to return to the doctor before coming back to therapy. Your doctor will be made aware of cancellations and "no-shows."
4. We are generally flexible with our ability to reschedule appointments. Please call us as soon as you know that you have a conflict in your schedule and we will try our best to accommodate your needs.
5. Physical therapy is covered under medical necessity on most insurance policies and therefore we must see you **on a weekly basis**. If you are unable to abide by this policy then we will have to remove you from our schedule.

Acknowledgement of receipt of Notice of Privacy Practices

By default, no other persons may have access to my medical records except the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize RPT to contact me, and leave messages, regarding my Physical Therapy care and/or appointments on the following numbers:

Home: _____ Cell: _____ Work: _____

I have read and understand the above attendance policy and Privacy Practices were reviewed.

Signature:_____ Date: _____