Date: _____

First Name: _____ **M.I.** ____ **Last Name:** _____

Gender: _____ **Date of Birth:** _____

Guarantor: Y/N

***If no, please provide name, date of birth, address and relationship to patient:

Name: _____ **DOB:** _____ **Relationship:** _____

Guarantor Address (if different from patient):

Address: _____ Unit/Apt #: _____

City: _____ State: _____ Zip Code: _____

Patient's Address:

Address: _____ Unit/Apt #: _____

City: _____ State: _____ Zip Code: _____

Contact Information: Mobile: _____ Email: _____

Other Numbers: _____

Insurance:

Name of Carrier: _____

Group #: _____ Subscriber ID: _____

*If the patient is not the insured, please provide the insured parties name, date of birth and gender:

_____

Who referred you to REAL pt? _____

Please provide the name of your primary care physician: _____

Which therapist would you prefer to work with?

☐ Adam Wolf ☐ Bill Hitchcock ☐ Alan Rodriguez

Please tell us about your past and current medical issues: _____

_____

_____

_____

Please list three goals you would like to achieve with REAL pt:

_____

_____

_____

CONSENT FOR CARE AND TREATMENT

I voluntarily consent to receive treatment at REAL pt, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I hereby authorize REAL pt, LLC to release information, verbal and written, contained in my medical record, and other related information to my insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries, and all other related persons as it relates to my treatment and/or payment for services provided.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge I have read and received a copy of the Notice of Privacy Practices. The provider is required by applicable federal and state law to maintain the privacy of your protected health information. We are required to give you a notice about our policy practices and your rights concerning you protected health information. We reserve the right to change our HIPAA Notice of Privacy Practices.

FINANCIAL RESPONSIBILITY

I understand that insurance coverage is not a guarantee of payment. I understand that I am ultimately responsible for services rendered by REAL pt, LLC. I will honor the REAL pt payment policy. All co-payments and patients that are self-pay are due in full at the time of service. Co-insurance and deductibles are the patient's responsibility. They will be invoiced once the Explanation of Benefits is provided by the patient's insurance carrier. Invoices are due 30 days after receipt. I authorize payments of benefits directly to REAL pt, LLC for services provided. REAL pt, LLC has the right to consult a collection agency if payment is past 90 days due. If any portion of the account balance exceeds 90 days the patient will be responsible for this amount plus interest of 1.5% per month, unless otherwise noted. I understand that I am financially responsible for payment of all services that are not paid by my insurance carrier. Should my account be referred to collection, I will be responsible to pay reasonable cost of collections including attorney fees. If I choose to be a self-pay patient I understand the fees are $180.00 for the initial visit and $155.00 for each follow-up visit.

SCHEDULE, CANCELLATION AND NO SHOW POLICY

REAL pt, LLC prides itself on providing its patients with dedicated time to meet your physical therapy needs and your schedule. Therefore, you agree to provide us at least 24 hours advance notice if you are unable to attend your scheduled appointment. If you do not cancel at least 24 hours prior to the scheduled start time of your appointment, you may be responsible for paying a cancellation fee of $100.00. If you do not show up for your scheduled appointment, you will be responsible for paying $125.00 for the appointment. All payments are non-refundable. REAL pt reserves the right to reschedule an appointment as necessary upon reasonable notice to the patient.

Signature: _____

Date: _____