Patient Information:

Patient Name	Birthdate	Age	M/F
Street Address	City	State	Zip
Home Phone #	Social Security #	Drivers License #	
Person to notify in case of emergency Relationship:		Phone #	

If patient is a minor:

Guardian		
Street Address		
City	State	Zip
Home Phone #	Work Phone #	

Employment Information:

Employer		
Street Address		
City	State	Zip
Work Phone #		

I hereby authorize Vincent Physical Therapy to perform any physical therapy treatment and evaluation, which are deemed necessary for my health care.

Signature Date

Benefits

Dear Patient:

All coinsurances, deductibles, and copays are **expected at the time of service**, no exceptions. Coinsurances and deductibles will be estimated based on an average visit cost and expected reimbursement from your insurance carrier. Vincent Physical Therapy will carry your account for sixty (60) days. If we are unable to collect payment from your insurance carrier, you will be responsible for the entire debt incurred for services rendered at Vincent Physical Therapy. Accounts remaining open after sixty (60) days are subject to a 1.5% per month late charge. Unpaid accounts will be turned over to collection. Vincent Physical Therapy requests that you call to cancel your appointment at least twenty-four (24) hours prior to the scheduled appointment.

This agreement is binding regardless of any legal transactions currently in progress or initiated during the course of physical therapy treatments, unless agreed upon in writing by Michel Vincent Physical Therapy.

Primary Insurance Carrier	Out of Pocket/Met	Annual Deductible/Met	CoPay/CoInsurance
Expected cost of 1st visit	Insurance Allowed Amount	CoPay/CoInsurance	To:
Expected cost of add'l visits	Insurance Allowed Amount	CoPay/CoInsurance	To:
Expected cost of add'l visits	Insurance Allowed Amount	CoPay/CoInsurance	To:
Physical Therapy Benefits:		Limitations:	

Assignment: I hereby assign my insurance benefits to be paid directly to Vincent Physical Therapy

Signature Date

I, _____, have read and do fully understand the above information provided for me and hereby agree to comply as out lined

_____ _____

Signature Date

Notice of Privacy Practices
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Vincent Physical Therapy. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. I acknowledge receipt of the Notice of Privacy Practices of Vincent Physical Therapy.

_____ _____

Signature Date