PURSUIT PHYSICAL THERAPY
Information Sheet

Today's Date:

PATIENT INFORMATION

Legal First Name	Legal Last Name	MI	DOB (mm/dd/yyyy)	Biological Type Male ☐ Female ☐
Preferred First Name (optional)	Preferred Last Name (optional)	Preferred Pronouns (optional)		

Home Address	City	State	Zip	Phone
Email Address		Preferred Appointment Reminder ☐ Call ☐ Email ☐ Text		

Marital Status ☐ Single ☐ Married ☐ Other	Where did you hear about us?

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Other	Employer	Phone

REFERRING PHYSICIAN INFORMATION

First Name	Last Name	Clinic Address	Phone

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

First Name	Last Name
Phone:	Email:

REASON FOR TODAY'S VISIT

Is this injury/condition related to one of the boxes below

Job Accident - L&I ☐ Yes ☐ No	Auto Accident MVA ☐ Yes ☐ No	Other Accident ☐ Yes ☐ No	Wellness/Maintenance (cash) ☐ Yes ☐ No	Date of Symptoms:

If job/auto related, L&I or MVA contact name	Case #	Phone

Reason for today's visit:

PRIMARY INSURANCE INFORMATION

Primary Insurance Name	Identification Number	Group Number	Ins Phone
Policyholder *(if other than patient)*	Phone (*policyholder*)	Relationship to Patient	
Employer *(of policyholder)*			

SECONDARY INSURANCE INFORMATION

Secondary Insurance Name	Identification Number	Group Number	Ins Phone
Policyholder *(if other than patient)*	Phone (*policyholder*)	Relationship to Patient	
Employer *(of policyholder)*			

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

Responsible Party Consent *(if other than patient)*	Date

HIPAA PRIVACY CONSENT AUTHORIZATION

I understand that Pursuit Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Pursuit Physical Therapy privacy consent form. I understand that I retain the right to revoke this consent by notifying the practice in writing with a signature at any time.

I have read and fully understand Pursuit Physical Therapy's Privacy Notice Consent Form

Patient Name _____ Date _____

DESIGNATED INDIVIDUALS' AUTHORIZATION FORM

I hereby authorize all the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment.

Authorized Designees

Name _____ Phone _____

Email Address _____ Relationship _____

Name _____ Phone _____

Email Address _____ Relationship _____

☐ I waive designating any individuals to receive my health information for my treatment with Pursuit Physical Therapy.

CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled and consent Pursuit Physical Therapy to filing insurance claims on my behalf. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I understand the services incurred at my visit may be determined to be not medically necessary, non-covered or investigational by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as pre-authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain this service noted below, **I agree to be financially responsible for all related charges, not covered by my insurance**:

Physical Therapy evaluation, Therapeutic Activities, Manual Therapy

$150 to $270

In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 4% per month (48% annually) for any unpaid balances over thirty days old.

I do hereby consent to treatment by the authorized personnel of Pursuit Physical Therapy as may be dictated by prudent medical practice, by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

I consent all information provided on this form is accurate to the best of my knowledge including my consent to the HIPAA Privacy Authorization.

Authorized Signature	Date

No Show and Late Cancellation Fee Policy

Pursuit Physical Therapy understands sometimes life gets in the way and you are not able to make the appointment time scheduled. We ask for a 24-hour notification if you need to cancel an appointment. If you no show to an appointment or cancel late (less than 24 hours), you may be charged a no show-late cancellation fee. This fee is equivalent to the cash rate of the physical therapist being seen. By signing below, you acknowledge and agree to this fee policy.

Authorized Signature	Date