Belnap & Brown | PHYSICAL THERAPY
BALANCE • SPORTS • SPINE

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ M or F

Cell Ph:_____ Home Ph:_____ Work Ph: _____

Address:_____City:_____ State: _____Zip:_____

Date of Birth:_____ SSN:_____Email:_____

EMERGENCY INFORMATION

Last Name: _____ First Name:_____

Relationship:_____ Phone:_____

REFERRING DOCTOR SECTION

Name of the Doctor who referred you: _____

Date of your follow up visit with this Doctor:_____

(Note: This date is needed so that we can send a progress report before this appointment)

How did you hear about Belnap & Brown Physical Therapy

1. Doctor:_____
2. Family Member/Friend:_____
3. Insurance:_____
4. Internet Search:_____
5. Other: _____

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account AS SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through Belnap and Brown Physical Therapy's billing department. These arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Belnap and Brown Physical Therapy. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY BELNAP AND BROWN, THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO THE SERVICES PROVIDED. This includes, but not limited to, services deemed 'non-covered' or 'not medically necessary' by my insurance.

Although I have requested Belnap and Brown Physical Therapy to bill my insurance company on my behalf, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE DIRECTLY TO BELNAP AND BROWN PHYSICAL THERAPY FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM. I also understand a $25.00 fee will be charged for all checks returned unpaid.

PATIENT'S SIGNATURE: _____ **DATE:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Signature:_____ Date: _____

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____ , herby consent to the therapeutic procedures outlined below, to be performed by Belnap and Brown Physical Therapy and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise program, vestibular rehabilitation, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, mechanical traction and ultrasound.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Belnap and Brown Physical Therapy, or from any other source.

I certify that I have read, and understand, the above consent statements:

Patient's Signature:_____ Date: _____