KERRY BECHT
PHYSICAL THERAPY & THERAPEUTIC MASSAGE

PATIENT INFORMATION

PLEASE PRINT LEGIBLY ON FORM		
Last Name:	First Name:	Middle initial:
Address:	City: State:	Zip:
DOB:	☐ Male ☐ Female	SSN#:
Home #:	Mobile #:	Work#:
Preferred Contact Number: ☐ Home ☐ Mobile ☐ Cell		
Email address:		
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Other:		
Employer:		

EMERGENCY CONTACT-REQUIRED

Last Name:	First Name:	Middle Initial:
Home #:	Mobile #:	Work #:
Relationship to patient: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ☐ Friend		

GUARANTOR/RESPONSIBLE PARTY IF OTHER THAN YOURSELF ☐ Check if all applies to above patient (SELF)

Last Name:	First Name:	Middle Initial:
Address:	City: State:	Zip:
Home #:	Mobile #:	Work#:
DOB:	☐ Male ☐ Female	SS#:
Relationship to patient: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Other:		

ACCIDENT INFORMATION

Was your injury a result of a work related or auto accident? ☐ Yes ☐ No If yes, ☐ Work ☐ Auto		
Work Comp or Auto insurance name:		Phone #:
Address:	City: State:	Zip:
Policy #:		Contact name:
Claim #:	Accident date:	Accident state:

REFERRING PROVIDER/PRIMARY CARE PHYSICIAN

Referring doctor:	Phone number:
DIRECT ACCESS PATIENTS: Please provide your primary care/preferred doctor's name and number below:	
PCP/Preferred doctor's name:	Phone Number:
Please note that without an initial prescription from your doctor we need a signed plan of care to continue beyond 30 days according to Tennessee state law.	

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AUTHORIZATION AND GUARANTEE

Please read each section below and initial:

_____ **MEDICARE** (if applicable): "I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

_____ **GUARANTEE OF PAYMENT** (not applicable for Worker's Compensation patients): "I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with Kerry Becht Physical Therapy become delinquent past 90 days and turned over to a collection agency, that I the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance."

_____ **CONSENT TO TREATMENT**: "I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Kerry Becht Physical Therapy."

_____ **WAIVER AND RELEASE**: "I hereby release, discharge and acquit Kerry Becht Physical Therapy, its agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

_____ **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**: "I consent to allow Kerry Becht Physical Therapy, to use and disclose my protected health information (PHI) within Kerry Becht Physical Therapy to carry out my treatment, to obtain payment and to carry out health care operation. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time to the extent that action has been taken in reliance on it. Withdrawal of consent shall be address in writing."

_____ **ASSIGNMENT OF BENEFITS**: "I authorize my health plan to pay benefits directly to Kerry Becht Physical Therapy. I understand that in the event my health plan or healthcare contract does not cover services or certain procedures, I will be responsible for payment. **Non-covered services may include strapping, use of Rock Tape, and Dry Needling**. I understand that if my health plan does not consider Kerry Becht Physical Therapy a participating provider, charges incurred will be paid by me. I further agree to accept full responsibility for payment of charges rendered to the above patient."

_____ **NOTICE OF PRIVACY**: "I acknowledge that a copy of the Notice of Private Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."

_____ **CANCELLATION / NO SHOW POLICY** "I understand that if I cannot give 24 hours advanced notice to cancel an appointment or if I fail to show for an appointment that I will be charged 30.00. I understand that if I do not show for 2 appointments that I may be discharged from physical therapy."

Patient/Legal representative signature:	Date: