Thank you for choosing Mrowka Physical Therapy! In order to serve you properly, please print the following information. All information will be kept strictly confidential. Thank you for your effort.

How did you hear about us? _____

PATIENT INFORMATION

Name (First, MI, Last)**	EMAIL
Address	Patient's Employer (**Parent/Guardian Name if Patient is a child)
City State Zip	Employer Address
Home Telephone	City State Zip
Cell Phone Number	Work Telephone
Date of Birth Age	Social Security #
Marital Status Single Married Divorced Widowed	Spouse/Partner's Name (if applicable)

PRIMARY INSURANCE INFORMATION

Primary Insurance Co.	Insurance ID Number
Name of Insured	Relationship to Insured
Insured SS#	Insured DOB
Insured Employer	Insured Employer's Address

SECONDARY INSURANCE

Secondary Insurance Co.	Insurance ID Number
Name of Insured.	Insured D.O.B./SS Number

Official Diagnosis or Chief Complaint _____

Reason for visit (if different from above) _____

Have you received Physical Therapy, Occupational Therapy, or Chiropractic in the past year? YES NO

If Yes, Same Condition? Yes No Different Condition? Diagnosis _____

Office that provided treatment _____

Emergency Contact

Name_____ Phone _____Relationship _____

Please list any family member(s) or friends that you authorize us to discuss any details of your care.

1._____Relationship _____

2. _____Relationship _____

ABOUT INSURANCE -- PLEASE READ CAREFULLY

Insurance is a method of reimbursing the patient for fees paid. It is NOT A SUBSTITUTE for payment.
It is your responsibility to pay any insurance deductible, co-payment, or co-insurance prior to insurance remuneration. As a courtesy to you, we will contact your insurance company in attempt to verify your coverage, deductible, or co-payment amounts. We encourage you to contact your insurance company to verify information.

Please realize we are not responsible for any misinformation your insurance company provides to us.
You are ultimately financially responsible for all charges.

I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim.

I authorize benefits to be assigned and payable to Mrowka Physical Therapy, P.C. This authorization will remain in effect unless revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

If this account is assigned to collection or to an attorney for suit, I shall be responsible for attorney's fees and costs of collection.

All of the above information I have provided is true and accurate. I agree to abide by the terms as listed above.

I am responsible for all charges, regardless of insurance coverage.

Signature_____ Date _____

CANCELLATIONS and MISSED APPOINTMENTS

When you schedule an appointment, we reserve that time for you. Missing appointments interferes with your progress in treatment. If you cannot keep your scheduled appointment, we need reasonable notice so that we may offer that time to someone else who needs it. Without reasonable notice, we do not have the opportunity to offer that time to someone else in need of services.

Patients are responsible for all appointments they have scheduled. Patients who choose not to attend or do not call to cancel appointments will be held responsible for these appointment times. The following policy will apply:

ONE WORKING-DAY NOTICE (24 HOURS) IS REQUIRED TO CANCEL AN APPOINTMENT

For a Late Cancellation or Missed Appointment, <u>You</u> will be responsible for paying the charges for that visit ($75.00-150.00,) based upon the scheduled appointment time reserved
(ex., <u>1 hour private</u> consultation/examination/orthotic casting will be charged at $150.00)

- Fees for missed appointments and/or late cancellations are expected to be paid at, or before the patient's next scheduled appointment. <u>Insurance does not cover these fees.</u>
- Missed Appointments may result in cancellation of any subsequent appointments scheduled. If you do not show for a scheduled appointment, we will cancel subsequent appointments, unless we inform you otherwise.
- During the course of treatment, any patient who misses more than 2 appointments without sufficient notice may be required to pre-pay for future scheduled sessions.

I agree to abide by the cancellation/missed appointment terms as listed above.

Patient Name _____

Signature of Client/Guardian _____
Date