3009 HWY 77, Suite G Panama City, FL 32405
Office 850-248-0241 Fax 850-248-0237

Patient's Name: ____

Patient's Date of Birth: ____

I prefer to be called: ____

Email Address so home exercises can be sent to you:

____

Home Address: ____

Patient's Cell Phone Number: ____

Please list name of Insurance Subscriber and their Date of Birth, this is the person who carries the insurance:

____

____

If you have VA Insurance we need your social security # for billing purposes:

____

Emergency Contact Name and Relationship: ____

Emergency Contact Phone #: ____

If you have been **feeling under the weather, exposed to covid, have covid, are having symptoms,** we ask that you please call our office so we can reschedule any appointments for you. **DO NOT** come to the office to cancel or reschedule your appointments. We ask that you call our office.

This is for the safety of our staff as well as our patients.

Please sign that you understand and agree to the above

____

Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom:

Name of Practice: RESTORE PHYSICAL THERAPY

Patient's Name: ______________________________

Date of Birth: ______________________________

Purpose of request - I authorize **Restore Physical Therapy** to disclose my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

You can list a Dr or Family member.

____

Name of Personal Representative Relationship Phone:

____

Address

____

City, State, Zip

Description of Information to be disclosed - I authorize **Restore Physical Therapy** to disclose all of my protected health information to my designated personal representative.

Expirations or termination of authorization - This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Restore Physical Therapy
3009 Hwy 77
Panama City, Florida 32405
Attn: Privacy Manager.

Redisclosure - We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of **Restore Physical Therapy**.

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Patient Signature Date

Policies and Informed Consent

Please review each policy, initial and sign where indicated. If you have any questions about these policies, please contact a Restore Physical therapy employee.

_______ **Cancellations:** We understand that life is unpredictable at times. There is a **$50.00 charge** for **"No-Show", "No-Call"** or **missed appointment, without proper 24 hour notification.**

_______ **Authorization for Release of Information and Assignment of Third Party Payments:** I hereby authorize Restore Physical Therapy to release all necessary information to any Insurance company, health plan, or third party payer, which may be responsible for paying or any medical services rendered by Restore Physical Therapy, including its physicians , therapist, or healthcare professionals, or employees. I authorize and direct all payers to assign such sums to Restore Physical Therapy. I understand this authorization shall remain dated by me. I understand such revocation shall not be effective for information released and/or charges incurred prior to such revocation.

_______ **Financial Policy:** I understand that unless I am a worker' compensation patient and have not met my maximum medical improvement, I am directly and completely responsible to Restore Physical Therapy for all charges not covered by my insurance, Medicare or other third party payor. I realize that if my third party payor fails to pay my balance in full or if there is no payment made on my account within 45 days of invoicing, it is my responsibility to pay my balance directly.

_______**Informed Consent:** I understand that I am voluntarily agreeing to participate in a physical therapy treatment program. I consent and authorize Restore Physical Therapy to perform therapy or clinical services consistent with my treatment plan. I have been informed of the risks of such a program, including but not limited to, abnormal blood pressure, fainting, dizziness, disorder of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand that the risk of bodily injury exists, including but not limited to, injuries to the muscles, ligaments, tendons and joints. Despite every effort by the staff to minimize these risks. I fully understand and accept the risks associated with physical therapy. It remains my desire to attend and participate in physical therapy treatment. I have consulted my physician prior to engaging in the physical therapy session(s).

_______ **Duty to Report:** I realize that it is necessary for me to promptly report any signs or symptoms of physical or medical abnormalities or distress. I agree that if I have any questions about the Procedures or methods used during a physical therapy session or tes, I will immediately ask my therapist and not proceed with the exercise until I am comfortable. I agree that If I feel any physical or medical abnormalities or discomfort during a physical therapy session, I will Immediately stop the session and report my feelings to my physical therapist.

_______ **Release and Hold Harmless:** I AGREE TO HOLD HARMLESS THE PHYSICAL THERAPIST AND RESTORE PHYSICAL THERAPY OR ANY OF ITS EMPLOYEES, OWNERS OR STAFF FROM INJURY, HARM, LOSS, OR ADVERSE EFFECT FROM PARTICIPATION IN THE PHYSICAL THERAPY SESSION THAT IS NOT DIRECTLY CAUSED BY THE NEGLIGENCE OF RESTORE PHYSICAL THERAPY. I HAVE READ THIS POLICIES AND INFORMED CONSENT AND VOLUNTARILY CONSENT TO PARTICIPATE IN PHYSICAL THERAPY. IN EXCHANGE FOR CONTINUING PARTICIPATION IN PHYSICAL THERAPY SESSIONS, I HEREBY RELEASE THE PHYSICAL THERAPIST AND RESTORE PHYSICAL THERAPY OR ANY OF ITS EMPLOYEES, OWNERS OR STAFF FROM ANY INJURY OR DAMAGES FROM SUCH PARTICIPATION UNLESS DIRECTLY CAUSED BY THE NEGLIGENCE OF RESTORE PHYSICAL THERAPY ARE NOT GUARANTEED, AND I AM FREE TO WITHDRAW FROM THE PHYSICAL THERAPY PROGRAM AT ANY TIME.

_______ Patient Acknowledgement, I certify with my signature below that:

- The information I have given to Restore Physical Therapy, including demographics and Insurance information is accurate.
- I have read, understand, and agree to the consents, released, and policies on this form.
- I have had the chance to ask any questions related to the information, policies, and terms on this form.
- All of my questions regarding this form have been answered.

______________________________	______________
Patient/Guardian Signature	Date
______________________________	______________
Patient Name (Print)	Patient Date of Birth
______________________________	______________
Guardian Name (Print)	Relationship to Patient

Your appointment time is valuable and has been reserved specifically for you. Failure to come to your appointment inconveniences other patients who may have requested an office visit during your appointment time.

A charge of $50.00 will be incurred.

Please read thoroughly and INITIAL the Following:

____ We understand that life is unpredictable at times. Restore Physical Therapy requires a **24 hour notice** for the cancellation of a scheduled appointment. A message can always be left on our voicemail to avoid a cancellation fee being charged. There is a **$50.00 charge** for **"No-Show", "No-Call"** or **missed appointment, without proper 24 hour notification.** This fee is not billable to your insurance. As a courtesy, we send text, voicemail or email reminder calls for appointments one day in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

____ **Please arrive on time** for your appointment. If you are 15 minutes late for an appointment you may be asked to reschedule. **Arriving late also changes the course of treatment for yourself and others.** If you are running late please call the office.

____ If you have 3 No-Shows, or are repeatedly late or cancel, your remaining appointments may be adjusted or canceled.

___ Out of respect for our staff and others we ask that you **PLEASE SILENCE YOUR CELL PHONE** while you are here for your appointment. If you must take a call, we ask that you please step outside. This may change the course of your treatment.

____ Copayments / Deductibles / Co-Insurance payments are **DUE AT THE TIME OF SERVICE.**

YES NO Are you here due to an injury involving an Automobile Accident?

WE DO NOT ACCEPT AUTO ACCIDENTS. IF YOU ANSWERED NO AND YOUR INSURANCE DENIES CLAIMS BECAUSE THIS IS DUE TO AN AUTO ACCIDENT YOU WILL BE RESPONSIBLE FOR ALL CHARGES!

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. Please sign and date below with your acknowledgement.

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Printed Name of Patient | Signature of Patient | Date