Senior Fit
Physical Therapy

NEW PATIENT INTAKE FORM

PATIENT INFORMATION:

Name: _____Date of Birth: _____

Address: _____City:_____Zip:_____

Home Phone: _____Cell:_____

Email: _____Text or Email Reminders? _____

Do you agree to allow SFPT to leave a voicemail message? ☑

How did you hear about SFPT? _____

Emergency Contact Name: _____Phone: _____

Referring Physician: _____Primary Care Physician: _____

Primary Insurance: _____Secondary Insurance:_____

POLICIES:

INSURANCE POLICY: The most recent insurance information has been provided. It is the responsibility of the patient to know his/her insurance benefits. Providing insurance information is not a guarantee of benefits. If you are in question of your benefits, please contact your insurance company to verify your benefits as soon as possible. If you have MEDICARE insurance and DO NOT have secondary/supplemental insurance, you are liable for the 20% in which Medicare does not cover, to include the initial deductible if it has not been met.

NO SHOW/CANCELLATION POLICY: In order to provide a true 1:1 therapy model, we ask that you attend and are on time for all scheduled appointments. If you cannot make an appointment we ask that you contact us 24 hours before your scheduled appointment time. That slot has been reserved for you and only you. If we do not have 24 hour notice are unable to fill the appointment time with another patient, you will be charged $25.

ASSIGNMENT AND RELEASE: I hereby authorize payment directly to SENIOR FIT PHYSICAL THERAPY LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. Should I default in payment, I agree to pay all cost of collectors, including collection agency fee, court cost, and any reasonable attorney fees up to 35% of the outstanding balance

HIPPA FORM: I have been given the HIPPA form to read and accept.

AUTHORIZATION TO RELEASE INFORMATION: I authorize SENIOR FIT PHYSICAL THERAPY LLC to release any information verbally or in writing required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize SENIOR FIT PHYSICAL THERAPY LLC to acquire any and all information that may be beneficial to my care.

I have read and understand the above information by signing below:

Signature of Responsible Party: _____Date: _____