



**premier**  
PHYSICAL THERAPY OF THE UPSTATE  
REHABILITATION & SPINE CLINIC

APPT DATE & TIME

THERAPIST

DIAGNOSIS

### **NEW PATIENT INFORMATION**

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #s: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact (outside your home): \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: Dr. \_\_\_\_\_ Primary Care: Dr. \_\_\_\_\_

Onset Date (injury, accident, surgery, date or recent date symptoms started)

\_\_\_\_\_

Primary Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's SSN# \_\_\_\_\_ Insured's name \_\_\_\_\_  
Insured's DOB \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City  
\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's SSN# \_\_\_\_\_ Insured's name  
\_\_\_\_\_ Insured's DOB \_\_\_\_\_

### **Billing Information**

Please present at scheduled appointment.

**Scheduling policy:** Your schedule is very important to us. Never hesitate to call us with **any** questions regarding scheduling. We will always do our best to accommodate your needs.

We need your help in serving you and the rest of our clientele. The following is in accordance with professional standards:

1. Cancellations require a 24 hour notification. For same day cancellation, there will be a **\$10.00 charge**.
2. Should you miss an appointment & are unable to contact us, this prevents us from having the opportunity to provide service in that time period. For No Shows, there will be a **\$20.00 charge**.
3. If you find you are running late for an appointment, please let us know as soon as possible. We will do all we can to accommodate you that day.

Again, please **call us** if you have any scheduling questions, since our goal is to provide you with quality service at all times.

### **CONSENT TO THERAPY**

I have read and fully understand Premier Physical Therapy of the Upstate LLC Notice of Information Practices. I understand that Premier Physical Therapy of the Upstate LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Premier Physical Therapy of the Upstate LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Premier Physical Therapy of the Upstate LLC Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

1. I have presented myself to this facility for therapy treatments and consent to diagnostic procedures and care provided by my attending therapist.
2. I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility.
3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service and **FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE** for any services not covered by this authorization.

**\*\*WORKERS COMPENSATION\*\*** I hereby authorize my rehab consultant to receive my records related to my work injury.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICIES AND CONSENT FORM AND ANY AND ALL QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

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\_\_\_\_\_  
Name and Signature of Patient (or Parent if patient is a minor-under 18)  
Date

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Witness (authorized signature of Premier Physical Therapy of the Upstate)