GAMBER PHYSICAL THERAPY & FITNESS

Experienced Personal One-on-One Care

Date _____ Time _____ NEW RETURNING

Name: _____ Best # to Contact? _____

Address: _____ Alternate Phone#: _____

City: _____ PA Zip: _____ SS#: _____

Birthdate: _____ E-MAIL: _____ Sex: _____

Employer: _____ Employer Phone: _____

Diagnosis: _____ Referring Physician: _____

_____ Family Physician: _____

PRIMARY Ins: _____ Phone: _____

ID#: _____ Group: _____ Eff Date: _____

Injury Date: _____ Adjuster: _____ Phone: _____

Card Holder: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ St: _____ Zip: _____

Ref/Auth? _____ Visits: _____ Expiration: _____

Tx Plan Info: _____ Ben Yr: _____ Vs Max: _____

COPAY per VISIT: _____ Coins: _____ Ded: _____ Met?: _____

NOTES: _____

☐ NONE SECONDARY Ins _____ Phone: _____

ID#: _____ Group: _____ Eff Date: _____

Card Holder: _____ Relationship: _____ DOB: _____

NOTES: _____

_____

********* VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT *********

EMERGENCY CONTACT (someone close by that is available, if needed): Phone: _____

Name: _____ Relationship: _____

In the last year, I HAVE/HAVE NOT (circle one) received rehabilitation services (includes physical therapy, occupational therapy, vision therapy, or chiropractic services). If yes, where _____

How did you hear about our office? Returning Patient OR _____

Did you request this office? Y or N Date: _____

I have reviewed the above and acknowledge that it is accurate X _____

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CONSENT FORM

PATIENT NAME: _____

CONSENT OF TREATMENT, RELEASE OF INFORMATION AND AGREEMENT OF FINANCIAL RESPONSIBILITY with GAMBER Physical Therapy & Fitness, LLC

I hereby give consent to the authorized personnel of GAMBER Physical Therapy & Fitness to perform an evaluation, render treatment, and provide physical therapy education to the above named patient.

I understand that GAMBER Physical Therapy & Fitness is in full compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, I understand that GAMBER Physical Therapy & Fitness is required to obtain patient information including protected health information (PHI) for the purpose of treatment, payment, and healthcare operation. I understand that my statement of complaint will not be met with retaliation.

I consent to have GAMBER Physical Therapy & Fitness release appropriate medical records to the physicians and other healthcare providers. Permission is given for the release of medical or other information necessary to assist with the physical therapy evaluation and treatment and to file a claim with the insurance company. In addition, information pertaining to the physical therapy treatment may be obtained from other medical providers.

I HEREBY AUTHORIZE **VERBAL OR WRITTEN RELEASE OF INFORMATION** TO THE FOLLOWING:

_____	_____	_____
Name of Person(s), IF any, you give permission to have access to your medical information GPTF has on file. (Your physicians are already included via above consent)	**Relationship to Patient**	**Date**

I herby authorize and request that payment of insurance benefits be made directly to GAMBER Physical Therapy & Fitness. I understand that I am financially responsible for any balance not covered by the insurance carrier. If patient balances go unpaid after several attempts to collect, the account may go to collections.

SIGNATURE OF PATIENT OR GUARDIAN: X _____

WITNESS: _____

DATE: _____