evolution
PHYSICAL THERAPY + YOGA

Patient Registration Form

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____/_____/_____ Gender: _____

Mailing Address _____ Physical Address _____

_____ _____

_____ _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship to Patient _____

Phone:_____ Address: _____

Email Address: _____

Attorney Name: (if applicable) _____ Phone: _____

Address: _____

_____

Was this injury the result of an accident? ☐ Work ☐ Auto ☐ Other ☐ None

Date of Injury: _____/_____/_____

Primary Care MD: _____ Phone: _____

Do you have a written prescription? □ Yes □ No

Referring Provider: _____ Phone: _____

To release medical information to a spouse, other family member, or assistant, please fill out.

I authorize _____ to discuss the following with Evolution Physical Therapy & Yoga.

□ Medical Records □ Insurance Information/Medical Bills

Relationship to patient:

□ Spouse □ Family Member □ Other _____

□ Parent/Guardian

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company, healthcare providers, or other appropriate party, as required, pertaining to treatment rendered to me by Evolution Physical Therapy. Further, I authorize Evolution Physical Therapy to obtain needed information from my physician or other health care provider, employer, or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed and provided by Evolution Physical Therapy, its employees, or representative. I understand that I am ultimately responsible for the charges related to my treatment.

All accounts are due and payable upon receipt of the bill.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been shown the posted Notice of Privacy Practices by Evolution Physical Therapy.

CANCELLATION POLICY

Evolution Physical Therapy requires patients to cancel appointments at least 24 hours prior to the appointment. Patients who cancel within the same day or miss an appointment will be charged a $25 fee, with the exception of an emergency.

We reserve the right to discharge a patient after two late cancellations or failure to show for the appointments.

I acknowledge that I am aware of the cancellation policy and agree to the terms of stated above.

_____ _____

Signature of Patient Date

For Minors/Under Age 18:

_____ _____ _____

Signature of Parent/Legal Guardian Printed Name Date