Patient Information

Last Name:	First Name:
Street Address:	
City:	State: Zip:
Date of Birth:	Male Female
Home #:	Cell #:
Preferred Contact Number: □ Home □ Cell	
Preferred Appointment Reminder: □ Voice □ Text	
Email Address:	
Employer:	

EMERGENCY CONTACT-REQUIRED

Last Name:	First Name:
Home #:	Cell #:
Relationship to patient: □ Spouse □ Parent □ Child □ Grandparent □ Sibling □ Friend	

GUARANTOR/RESPONSIBLE PARTY (IF OTHER THAN YOURSELF)

Last Name:	First Name:
Street Address:	
City:	State: Zip:
Home #:	Cell #:
DOB:	□ Male □ Female
Relationship to patient: □ Spouse □ Parent □ Child □ Grandparent □ Other:	

ACCIDENT INFORMATION

Was your injury a result of a work related or auto accident? □Yes □No If yes, □Work □Auto		
Work Comp or Auto insurance name:		
Address: City: State: Zip:		
Contact Name:		Phone #
Claim #:	Date of Accident:	Accident state:

DIRECT ACCESS

Please note, without an initial prescription from your doctor, we need a signed plan of care to continue treatment beyond 15 visits or 30 days according to Tennessee state law. If you are attending therapy without a prescription, please provide your primary care or preferred physician's name and we will forward your plan of care to them.

PCP/Preferred Physician's Name: ________________________ Phone: ____________________

Privacy and Benefits

Waiver and Release: "I hereby release, discharge and acquit Kerry Becht Physical Therapy & Massage, Inc., its agents, representatives, affiliates, employees or assignees of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance services, Emergency Medical Technicians, physicians or urgent care services."

Informed Consent: I understand that as a patient of Kerry Becht Physical Therapy & Massage, Inc.:

- I have the right to receive complete and current information concerning my diagnosis (to the degree known by Kerry Becht Physical Therapy & Massage, Inc.), treatment, and any known prognosis. This information will be communicated to me in terms I can understand by my therapist.
- I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, Kerry Becht Physical Therapy & Massage, Inc. has the right to terminate the relationship with me.
- Patient's Rights will be posted in a prominent location in the office for my review and I can discuss any questions I have with my therapist.

Privacy Policy: I acknowledge that I have received a copy of Kerry Becht Physical Therapy & Massage, Inc. Privacy Practices. I understand there is a copy of Kerry Becht Physical Therapy & Massage, Inc. Privacy Practices posted and it is my right to request a copy of the Privacy Policy at any time. I also understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax.

Is there anyone (family, spouse, children, or friend) involved in your care or payment related to your care that we can share your health information? □ YES □ NO
If yes, please list contact person's name: ____

I acknowledge and agree that Kerry Becht Physical Therapy & Massage, Inc. and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any phone number I have provided, and any other phone number associated with my account, including wireless/mobile phone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Kerry Becht Physical Therapy & Massage, Inc. if I have given up ownership or control of any such phone number.

Assignment of Benefits: I hereby assign all benefits directly to Kerry Becht Physical Therapy & Massage, Inc. and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment. Any overpayment will be reimbursed after all claims have been processed and paid through insurances.

Cancellation/No Show Policy: "I understand that if I cannot give 24 hours advanced notice to cancel an appointment or if I fail to show for an appointment that I will be charged $30.00. I understand that if I do not show for 2 appointments that I may be discharged from physical therapy."

Patient's Signature: ____ Date: ____________________