ACTIV Physical Therapy
3807 Brecksville Rd
Richfield, OH 44286
Phone: 330-659-4050
Fax: 330-659-4052

PATIENT INFORMATION

Last Name ______________________ First Name ______________________ Gender ________

Date of Birth ______________________ Primary Phone ______________________

Address ______________________ City, State, Zip ______________________

Email address ______________________

Parent Email ______________________ Parent Email ______________________

INSURANCE INFO

Insurance Company ______________________ ◻ ADDRESS OF POLICYHOLDER IS SAME AS ABOVE

Policyholder ______________________ Other Address ______________________

Date of Birth ____________ Cell Phone ____________ Relationship to Patient ____________

EMERGENCY CONTACT INFORMATION - Please list at least one contact

Name ______________________ Name ______________________

Relation ______________________ Relation ______________________

Phone ______________________ Phone ______________________

WHAT BRINGS YOU TO PHYSICAL THERAPY?

Problem? ______________________ Since When? ____________

Date of Surgery ____________ Special Concerns ______________________

PHYSICIAN INFORMATION

Referring Provider ______________________ Phone Number ____________ City ________

Family Physician ______________________ Phone Number ____________ City ________

CONTACTING YOU

We send appointment reminders **via email** the day before your appointment. **We will also use this email for statements, information regarding your insurance, and other important communication**. Please list the most appropriate email that you check regularly. If you prefer communication via phone, list the best number you can be reached at.

HOW DID YOU HEAR ABOUT US?

Who can we thank?

INSURANCE INFORMATION (CONTINUED ON BACK)

Please read and initial each section.

CONSENT OF TREATMENT & ASSIGNMENT OF BENEFITS

I hereby authorize ACTIV Physical Therapy through its appropiate personnel, to perform or to have performed on me, or the above named patient, appropriate assessment and treatment prcedures relating to my, or the above names patient's stated condition.

I request that payment for applicable insurance benefits be made on my behalf to ACTIV Physical Therapy, LLC for services rendered by ACTIV Physical Therapy, LLC. I certify that the information I have reported with regard to my health insurance coverage, to the best of my knowledge, accurate. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

Initial here ____________

CONTACTING YOUR PHYSICIAN/PROVIDER

Ohio law states that you DO NOT need a prescription to see a physical therapist. **If you are self-referred, we need your permission** to send communication to your family physician or any other provider. Based on important findings following your initial examination, your therapist may refer you to your family physician or to a specialized physician for further medical evaluation.

☐ Permission to send communications about this course of care at ACTIV PT to family physician and/or other listed providers

☐ Please DO NOT send communication to my family physician (only if you are self-reffered)

Initial here_________

STATEMENT OF FINANCIAL RESPONSIBILITY

I have read ACTIV Physical Therapy's Financial Policy (available at www.ACTIVpt.com or by request) that explains my Financial Responsibility to ACTIV PT for providing physical therapy services to me or the above named patient. I agree to review my insurance policy's "Schedule of Benefits". I agree to inform ACTIV PT of any insurance changes during my treatment. I agree to pay copayments, deductible (if applicable), coinsurance, and any uncovered services or products at the time of service.

I agree to make timely payments to ACTIV Physical Therapy for the entire amount of my statement balance remaining after my health insurance has paid its portion and treatment has ended. I understand that I am responsbible for services not covered by my health insurance policy.

Note: Any estimates of benefits disclosed to us by the insurance representative are merely estimated coverage information we obtain, and are in no way intended to release the patient from total responsibility for their account or be implied as guarantee of payment by the insurance carrier. The patient will be financially responsible for all charges not covered or not paid for by said insurance.

☐ Bill Insurance

☐ Self-Pay

Initial here_________

ATTENDANCE POLICY

I understand that good attendance is essential to receive the most benefit from my therapy program. I will inform ACTIV Physical Therapy if I am unable to keep my appointment and give up to 24 hours notice, if possible. I understand that ACTIV PT will make every effort to reschedule my appointment. If I am late for an appointment, I understand the therapist will see me as the schedule permits.

RELEASE OF INFORMATION (HIPAA)

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information by ACTIV Physical Therapy, LLC for the purposes of treatment, payment, and to carry out other necessary healthcare operations.

I understand and acknowledge that I have the right to request that ACTIV Physical Therapy restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that ACTIV PT is not required to agree to restrictions requested by me, but if ACTIV PT agrees to such requests, it will be bound by that restriction until I notify otherwise in writing.

If you have specific requests for restrictions, please ask the front desk for an additional form.

Signature of Patient or Representative	Today's Date
Patient's Name	Date of Birth
Name of Patient's Representative	Relationship to Patient