
ACCIDENT RELATED (IF APPLICABLE)

Date of First Symptom: ____M____D____Y Employment Related: Yes No Lawsuit Involved: Yes NoDescription/Type of Accident and Symptoms:

PARENT OR GUARDIAN (IF APPLICABLE)

Title, First, Middle, Last Name:

Sex: Male Female

Street Address:

City, State, Zip:

Relation to Patient:

Social Security #: - -

DOB: ____M____D____Y

POLICY DISCLOSURES

As a courtesy, we will bill your insurance company for applicable rehabilitation services performed. For the convenience of our patients, we also offer select rehabilitation products (typically used at home or work) for purchase at our Centers. Please note we do not bill insurance for these products. Co-pays are due at the time of service rendering. The patient is ultimately responsible for any balance that is not paid, reduced, or delayed by insurance.

Please provide us with at least twenty-four hours notice should you need to reschedule or cancel an appointment. Patients that arrive fifteen or more minutes late or without a prescription for certain services may be asked to reschedule their visit.

Complementary lockers are available at no charge to our patients during their visit. Patient items found at the Center will be placed in our lost and found for thirty days. We are not able to accept liability for any personal items brought to the Center.

We are a smoke-free environment.

CONSENT FOR TREATMENT AND BENEFITS

My signature is required below to authorize treatment. My signature also authorizes the release of my medical information (including but not limited to my physician, insurance company, employer, school, related health care provider, nurse, case manager, attorney, assignees, beneficiaries, and all other related persons to my treatment) that is needed to process my claim. I also agree to a direct assignment of my benefits to High Performance Physical Therapy Centers, LLC d/b/a Atlanta Falcons Physical Therapy Centers where a claim has been filed, the payment of medical benefits directly to this practice for services rendered, and to comply with the above policies. We reserve the right to change our policies without prior notice.

I am aware of my diagnosis and voluntarily consent to treatment at this practice. No guarantees have been made to me about the outcome of care provided at this practice. I agree to pay for the services rendered and to cooperate in providing information necessary to process my claim(s) with third-party payers. Where the law or my insurance contract does not prohibit payment by me, I accept responsibility to pay any and all of my account balances (even if the balance differs from the benefit verification form as said form is not a guarantee for coverage). A photo copy or carbon copy of this agreement shall be as effective and valid as the original. All information provided on this document is accurate to the best of my knowledge.

Patient Signature:

Date:

Parent/Guardian's Signature:

Parent/Guardian's Name:

Date:

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORD INFORMATION

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for Atlanta Falcons Physical Therapy Centers. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my treatment.

Patient Signature:

Patient Name:

Date:

Parent/Guardian's Signature:

Parent/Guardian's Name:

Date:

Thank you for completing this form!