



## EAST SACRAMENTO PHYSICAL THERAPY

3400 Elvas Avenue Sacramento, CA 95819  
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### Patient Information Form

Name \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sex assigned at birth \_\_\_\_\_ Gender Identity \_\_\_\_\_ Gender pronouns \_\_\_\_\_

Email Address \_\_\_\_\_

Marital Status: \_\_\_\_\_ Emergency Contact, friend or relative \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

Subscriber ID# \_\_\_\_\_ Authorization # \_\_\_\_\_

Number of Visits authorized \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_

**\*\*\* DEDUCTABLE MUST BE MET FOR INSURANCE TO COVER VISITS\*\***

The referral department will request authorization from your Insurance if additional visits are recommended by your treating physical therapist for your continued care beyond this initial authorization.

I give East Sacramento Physical Therapy permission to bill my insurance. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account or any professional services rendered. I certify all information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature for Minor \_\_\_\_\_ Date: \_\_\_\_\_

## Policy for 50.00 Cancellation and No Show Fee

There is a \$50.00 cancellation/no show fee if you cancel your appointment less than 24 hours ahead of your scheduled appointment time or if you no show for your scheduled appointment. Your treatments are very important to your overall health and wellbeing. We are working with your physician to make sure your therapy plan is complete and successful. Kindly notify us if you are unable to keep your appointment no less than 24 hours ahead of time.

I have been made aware of the cancellation no show policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature for Minor \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you may be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure, and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty that could cause an increase in your current level of pain or discomfort or an aggravation to you existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read and received a copy of the consent form and authorized release of medical information to appropriate third parties.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature for Minor \_\_\_\_\_ Date \_\_\_\_\_