PENINSULA Physical Therapy
Sports·Orthopedics·Hands

Please complete ALL sections

Referring Physician:	Primary Care Physician:	Date:

PATIENT INFORMATION

Patient Last Name:	First:	MI:	Date of Birth:	Age:

Mailing Address:	City:	Zip Code:

E-Mail:	**Male** **Female**	Primary Phone # • home • cell • work

Social Security Number:	Employer: (subscriber)	Secondary Phone # • home • cell • work

Emergency Contact Full Name:	Circle One: parent spouse friend	Contact phone number(s):	OK to disclose medical information with said emergency contact? YES NO

Automated Appointment Reminder Preference (circle one): **Text Message** **Phone Call** Reminder to **primary** or **secondary**?

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD (if applicable)
Effective 5/1/09 for identity theft security, we are now required to obtain a copy of your valid driver's license and/or picture ID

CANCELATION/NO SHOW POLICY

We require **12-hour advance notice** of a canceled or rescheduled appointment. If 12-hour notice is not given, we will charge a **$25.00 fee** for the missed appointment. Insurance companies **DO NOT** pay for this; therefore you will be responsible for that charge. There will be an additional charge of **$25.00** for a check returned for non-sufficient funds.

PRIVACY PRACTICES SUMMARY

By signing this form, I am acknowledging that I have the option to receive a copy of Peninsula Physical Therapy's statement of privacy practices, or have declined to receive a copy. I understand that I can get a copy of the aforementioned statement of privacy practices at any time upon request. The statement explains how we use and disclose health information. If for payment purposes your insurance company requests a copy of your medical records, we will release the requested records to your insurance company. For optimal treatment, we also share information regarding your injury/illness with your doctor. If for any reason you do not wish for either your doctor or insurance company to have copies of these records, or any party described in our privacy practices, you must inform Peninsula Physical Therapy in writing. Peninsula Physical Therapy may also release medical information about you to a family member or a friend involved in medical treatment or payment of the medical bills. Unless specified, Peninsula Physical Therapy may also leave messages at your home/work regarding appointments or if we need to contact you. By signing below, you are agreeing to the terms listed above.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND FEES AND ATTEST ALL INFORMATION I HAVE PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE:

Patient / Guardian signature	**Date:**