**Welcome** to THRIVE Physical Therapy, Inc.! We are pleased you have selected us as your physical therapy provider. Please review and sign below to confirm your agreement to the following policies regarding prescriptions, billing, cancellation policies, assignment and release, as well as consent to treatment.

***Prescriptions***:

Virginia state law generally requires a current written prescription from your physician to receive physical therapy care. Our services will be limited to the treatment described in the physician's order.

***Patient Payments/Billing***:

Your insurance plan may require co-payments, co-insurance, and/or have a deductible. *Payment at the time of service is preferred and appreciated, and we accept checks, cash, Visa and Master Card*. If payment is not made at the time of service, you will remain responsible for any balance due. As a courtesy to our patients, we process the filing of insurance claims. If you are in litigation or have been in an auto accident and are relying on third party insurance, any unpaid balance is your responsibility. Please inform us immediately of any changes to your contact information and/or insurance coverage.
*NOTE: If authorization is required for Physical Therapy, please help us keep track of your appointments.*

***Cancellations***:

Our policy requires patients to give **24 hours' notice** for cancellation of a scheduled appointment. If proper notice is not given or you do not show for an appointment, you agree to pay a **$30.00** fee. This amount is not billable to any insurance carrier and shall be paid by you personally.

***Assignment and Release***:

I confirm that I have insurance coverage with the insurance carrier listed on my registration form and assign directly to THRIVE Physical Therapy, Inc. all medical benefits, if any, otherwise payable to me by such insurance carrier for services rendered. I hereby authorize THRIVE to release all information necessary to secure the payment of benefits from my insurance carrier. I authorize the use of my signature on all such insurance submissions.

***Responsibility for Payment***:

I understand that I am fully responsible for all fees and charges for services rendered by THRIVE whether or not paid by my insurance company. I understand and agree that if I fail to pay any fees or other charges associated with services rendered by THRIVE within 30 days of billing, interest will accrue at the rate of 1.5% per month on the outstanding balance. In addition, if THRIVE engages an attorney to collect any balance due, I agree to pay all court costs associated with any legal action plus attorney's fees equal to 25% of the balance due.
*Please Note: Additional charges are associated with Dry Needling, Taping and purchase of equipment.*

***Consent to Treatment/Medical Services Agreement***:

I hereby authorize THRIVE to render medical services to me or my minor child named below and to release any information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company regarding my claim. I understand that I am financially responsible for all fees and charges arising for the treatment of the patient named below.

I hereby consent to any medical treatment and evaluative procedures as the licensed physical therapist considers necessary or advisable. I understand this may include, but not limited to, orthopedic evaluation, modalities or manual treatment. I am aware and affirm that no guarantees have been made to me concerning treatment by THRIVE.

I have read and understand this form and its contents. By signing this document, I acknowledge my consent to the above.

_________________________________ ___________________
Patient (or Guardian's) Signature Date

_________________________________
Print Name of Patient

_________________________________
Print Name of Guardian and Relationship (if Patient is a minor)

## PATIENT REGISTRATION

Patient Name (Last)____________________________ (First)______________________________ (MI)_______

Address _____________________________________ City_________________ State______ Zip _______

Gender: M F SSN _____ - _____ - _______ Date of Birth ____________________ Age ________

Home Phone #________________ Work Phone #_________________ Cell Phone #__________________

Email: ________________________________________________ Marital Status _________________

Referring Physician: _________________________________________ Phone # _______________________

Employment Status: Full Time ☐ Part Time ☐ Retired ☐ Student ☐

Employer Name: ____________________________________________ Phone # ____________________

Employer Address _____________________________ City_______________ State ______ Zip _________

Responsible Party Name_________________________________________ Phone # ____________________

Address ________________________________________________________________________________

**EMERGENCY CONTACT**

Name___________________________________ Relation _____________ Phone # ___________________

## PRIMARY INSURANCE

Insurance Company Name ______________________________________ Phone # ____________________

Subscriber ID # _______________________ Group # __________________ Relation? ________________

Subscriber's Name _____________________________ Date of Birth ____ / ____ / ________ M F

Subscriber's Address_____________________________________________________________________

Auto / Personal Injury? Y / N Date of Accident ____ / ____ / ______ State ______________________

Auto Insurance Company Name ___________________________________ Phone # _________________

Attorney Name _________________________________________________ Phone # _________________

Work Injury? Y / N If yes, Employer Name _____________________________ Phone # _________________

Employer Address _______________________________________________________________________

Workman's Comp Case Mgr Name __________________________________ Phone #_________________

Workman's Comp Claim # __________________________________ Date of Injury ____ / ____ / ______

## SECONDARY INSURANCE

Insurance Company Name ______________________________________ Phone # _____________________

Subscriber ID # _______________________ Group # __________________ Relation? _________________

Subscriber's Name _____________________________ Date of Birth ____ / ____ / ________ M F

Subscriber's Address_________________________________________________________________________

## REFERRAL INFORMATION

Who may we thank for referring you to our office? __________________________________________________