DIRECT
PHYSICAL THERAPY

PATIENT INFORMATION

NAME: (First, MI, Last)_____ DATE OF BIRTH: _____ AGE:_____

ADDRESS _____CITY: _____ST:_____ ZIP:_____

CELL #: _____HOME #:_____EMAIL:_____

EMERGENCY CONTACT #: _____ NAME/RELATIONSHIP:_____

EMPLOYER:_____OCCUPATION:_____

HOW DID YOU HEAR ABOUT DIRECT PHYSICAL THERAPY?

☐ Dr. ☐ Facebook ☐ Friend / Relative _____

☐ Insurance ☐ Instagram ☐ Other _____

PAYMENT AUTHORIZATION & CONSENT

I authorize payment to Direct Physical Therapy, PLLC for all physical therapy services rendered. I also understand I am responsible for knowing my co-payment amount, my deductible amount and for the balance on my account for any professional services rendered. I consent that if my insurance company for any reason denies payment of services, I will be billed $150 for an evaluation and $75 per visit for services that have been rendered.

I consent to the release of information and/or disclosure to Direct Physical Therapy, PLLC of all or any part of my record to other health care providers involved in my care or a third-party payer as is necessary for processing claims. I agree that I am responsible for forwarding to Direct Physical Therapy, PLLC any insurance payment check(s) that are mailed to my home for services received at Direct Physical Therapy, PLLC. I agree to do so within 14 days of receipt of check(s).

As a courtesy to our other patients, as well as our staff members, Direct Physical Therapy, PLLC asks for a 24 hour notification of cancellation prior to your scheduled appointment. Please note without notification a fee of $25 will be billed to you or will be collected upon your next visit.

I consent to be assessed by and to receive treatment from Direct Physical Therapy, PLLC consistent with a plan of care. I confirm that I have been informed and I have participated in planning the care and procedure(s) to be carried out by Direct Physical Therapy, PLLC and sign this consent willingly and voluntarily.

I have read and completely understand all of the office policies listed above.

PATIENT / GUARDIAN SIGNATURE: _____ DATE:_____

*I consent for our staff to speak with your significant other, close family member and/or another designated individual **only if listed below**. Please understand this is waiving your right to confidentiality if consent is given.*

Consent given to: _____ Relationship: _____

DIRECT PHYSICAL THERAPY, PLLC
51 SMART AVENUE, SUITE 100
YONKERS, NY 10704
914-964-8169 PHONE 914-476-4514 FAX

****INTERNAL USE ONLY*****
Dr. Referral / Rx ____
Copy of Ins Card(s) ____
Patient Signature ____