InSynch Physical Therapy PLLC

Patient Registration

Patient Information

Where did you hear about In Synch PT? _____

Name_____

Birth date_____ Male ◯ Female ◯ Marital Status: Single ◯ Married ◯ Other ◯

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone_____ WorkPhone _____

Email Address _____ Primary Care Physician _____

Employer/School_____ Employer Address (city)_____

Emergency Contact Name _____ Emergency Contact Relationship _____

Occupation / Tasks _____ Emergency Contact Phone_____

Date of Injury / Onset of Condition _____ Nature of injury/condition _____

Is your injury/condition related to: your job? ◯ a car accident? ◯ other? ◯

Person Responsible for Bill *(if different from patient)*

Name_____ Home Phone_____

Address _____ Work Phone _____

City/State/Zip _____ Relationship _____

Stephen L. Thompson, DPT | 1421 34th Ave. | Suite 206 | Seattle, WA 98122 | 206.375.3616
steve@insynchpt.com • *www.insynchpt.com*

Release & Authorization for Charges

- By signing below I certify that I and/or my dependent have insurance coverage with

_____

and hereby authorize my insurance company to pay directly to In Synch Physical Therapy, PLLC, the amounts due for services rendered to me or to my dependent.

- I authorize the release of my Physical Therapy records as needed to process my insurance claim, as well as with other healthcare providers, if needed, to allow better collaboration between providers.
- I understand that I am responsible for all unpaid charges owed to **In Synch Physical Therapy, PLLC** whether or not covered by insurance. I understand that there will be a $25 charge for any check returned for insufficient funds.
- I also understand that it is my responsibility to determine the physical therapy benefits that apply to my specific insurance plan. This includes, but is not limited to, necessary physician referrals or prescriptions, deductibles, pre-authorization, percentage payout, provider discounts and yearly coverage.

_____ _____

Signature *Date*

_____ _____

Signature of Patient or Personal Representative/Guardian *Date Signed*

_____

Printed Name of Patient

Cancellation Policy

Due to the nature of the practice, a cancellation policy is in effect. You are responsible for calling or emailing **In Synch Physical Therapy, PLLC** and canceling your appointment at least 24 hours in advance, or your account will be charged $50. Exceptions are made only for personal and family illnesses and emergencies. Patients who miss their first appointment without canceling, or two follow up appointments without giving 24 hours notice of cancellation, will not be given future appointments.

By signing below, I attest that I have read, understand, and agree to abide by the above cancellation policy as set forth by In Synch Physical Therapy, PLLC.

_____ _____

Signature *Date*