Professional Therapy Associates, Inc.

3900 Medina Road, Suite N Akron, OH 44333 330-665-0006 fax: 330-665-0008

Please provide your Driver's License and Insurance card(s) on your 1st visit

Patient Name	Male ☐ Female ☐	
Address	Date of Birth	Age _____
City State	Zip	
Home Phone Cell Phone	Social Security #	
E-Mail Address		
Employer	Circle: Single Married	
Employer Address	Employer Phone	
City	State	Zip
Responsible for Account (if not patient)	Relationship to Patient	
Responsible Person Address	Phone	
City	State	Zip
Emergency Contact	Relationship to Patient	
Emergency Contact Phone		
Referring Physician	Area of pain	
Has patient had chiropractic, physical, occupational or speech therapy this year? Yes ☐ No ☐ # of visits____		
Date of Onset/Injury _____________	Is Condition Related to: Auto ☐ Employment ☐	
How did you become aware of our services?		
Worker's Comp Patients MUST Provide Current C-9 Before Initial Date of Service		
If this is an accident and you have hired an attorney please provide that information to us prior to treatment.		

2.5% WILL BE ADDED TO ALL UNPAID BALANCES EVERY 28 DAYS

I UNDERSTAND THAT THERE IS A $40 FEE FOR ANY MISSED APPOINTMENT WITHOUT 24 HR NOTIFICATION. IF I AM LATE FOR AN APPOINTMENT I MAY BE ASKED TO RESCHEDULE.

(Optional) Please remind me by text _____ or e-mail_____ of my appointment times.

PATIENT SIGNATURE_________________________________ **Date**______________

(If patient is under 18 a Parent or Guardian must sign)

PATIENT CONSENT FORM

I hereby authorize Professional Therapy Associates, Inc. and any of their representatives to provide physical therapy to myself or to any minor (under age 18) that I represent. I understand that by signing this form myself, or the minor I represent, are consenting to treatment.

AUTHORIZATION TO OBTAIN INFORMATION

I understand that I am authorizing Professional Therapy Associates, Inc. to obtain any test results or patient information in order to assist with the provision of care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that I am authorizing Professional Therapy Associates, Inc. to release any and all pertinent information regarding my physical therapy to my doctor, insurance co., attorney, etc.

ASSIGNMENT BY RESPONSIBLE PARTY/FILE SIGNATURE

In consideration of any medical care provided to the patient named below, I assign to Professional Therapy Associates, Inc. all my rights to any and all medical insurance benefits to which I am or may be entitled by any health plan. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original.

PAYMENT POLICY

I understand that I am responsible for any balance after my insurance considers their liability(regardless of whether I have hired an attorney for an accident claim). I understand that it is my responsibility to check if physical therapy is a covered item in my medical insurance plan. I also understand that I am responsible for any referrals and knowing any limitations (number of visits) that my insurance plan may have, including medical supplies. Medicare requires you to see a physician every 30 days to remain eligible for coverage for therapy. I also understand that most insurance companies may not pay for some durable medical equipment. I UNDERSTAND THAT IT IS ULTIMATELY MY RESPONSIBILITY TO PAY FOR ANY AND ALL SERVICES PROVIDED TO ME BY PROFESSIONAL THERAPY ASSOCIATES, INC.

______________________________ ____________________
Patient/Guardian Signature Date

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Professional Therapy Associates reserves the right to modify the privacy practices outlined in the notice.

I certify that I have received a copy of the Notice of Privacy Practices for Professional Therapy Associates, Inc.

____
Name of Patient

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor, or an adult who is unable to sign this form)

____
Relationship to Patient

___It is okay to leave a message on my answering machine.

___It is okay to discuss my medical condition with ____________________

This is a teaching facility, and on occasion, we have students observing and/or treating patients.

___ I do approve of students observing/assisting with my treatment.

___ I do **not** approve of students observing/assisting with my treatment.