HEALTH-PRO PHYSICAL THERAPY

110 LA CASA VIA, SUITE 100, WALNUT CREEK, CA 94598
PHONE: 925-935-4866 FAX: 925-935-8873

PLEASE PRINT Today's Date:________________

Name____ Home #:(_____)________________
E-mail Address____ Cell #:(_____)__________________
Address:____ Date of Birth:_____/_______/______
City:________________________ State:_____ Zip:__________ Social Security #__________________________
Patient Status: (please circle) Single Married Widowed Divorced Separated
Age:_____ Sex: _____ Employed____ F/T student_____ P/T student_____
Employer:__________________________ Occupation: ______________________________
Address: ____ Phone: (______)___________________________
City: __________________________ State: ______ Zip: ___________
Emergency contact:______________________________ Relationship:_____________________________
Phone: (______)__________ Address:____

Reason for Therapy: (please circle) Work Auto Home Other
Date of Injury:_____/____/______ Adjustor if applicable: ______________________________
Worker's Comp/MVA Claim #:_______________________ Adjustor Phone #: _________________________

Referring Doctor:______________________________ Diagnosis:_____________________________
Doctor Address:____ Phone#:_______________
Date of Surgery(if applicable):____/_____/_____ Type of Surgery:_____________________

Insurance Company Name_____________________________ Phone:(____)_________________
Group #:_______________ Policy #: ________________ Medicare #:___________________

How did you hear about Health-Pro Physical Therapy? ____

If referred by an individual, may we thank him or her? Yes No Phone #:__________________________

How did you find our phone number? ____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

I UNDERSTAND THAT MY INSURANCE CARRIER OR PAYOR OF MY MEDICAL BENEFITS MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES OR NO PAYMENTS AT ALL FOR WHATSOEVER REASON.

I UNDERSTAND THAT HEALTH-PRO PHYSICAL THERAPY BILLS MY INSURANCE AS A COURTESY.

I UNDERSTAND THAT 24 HOURS NOTICE IS REQUIRED FOR CANCELLATION OF APPOINTMENTS.

I UNDERSTAND THAT THERE WILL BE A $75 CHARGE FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT SUFFICIENT PRIOR NOTICE.

I ACKNOWLEDGE I HAVE READ, UNDERSTOOD AND SIGNED THE WELCOME LETTER/POLICIES OF HEALTH-PRO PHYSICAL THERAPY, INC.

Signature: ____ Date:___________________

Please give your insurance card to the receptionist so we can make a copy for your file.