RestoreRehab
PHYSICAL THERAPY

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Patient Registration

Name_____ _____ ____ _____
Last First MI DOB Male Female

Address_____
Street Apt # City State ZIP

Phone (h) _____ (w)_____(m)_____ E-mail _____

Emergency Contact_____
Name Relationship Phone #

How did you hear about us _____

Employer _____

Primary Health Insurance _____ Secondary Health Insurance _____

Policy Holder_____
Name Relationship

Referring Physician_____

Cancellation / No Show / Re-scheduling Policy

1. **It is very important to come to all of your appointments to receive the best care.** If you have two cancellations in a row, all subsequent appointment will require a **non-refundable deposit of $50.00**. In addition, this may require a new evaluation.
2. **Cancellations/Rescheduling.** If you need to cancel an appointment, please call more than 24 hours prior to the appointment. Otherwise, you will be charged a **no show/ cancellation fee of $50.00**

I, _____, hereby certify that I have read, reviewed and understand the above Cancellation / No Show / Re-scheduling Policy.

SIGNATURE:_____ Date: _____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature: _____ Date:_____

How may we contact you? Via email_____ telephone_____ text_____ fax_____ voicemail_____

Notice of Advice

Under New York's Direct Access Law, you may be treated by a physical therapist without a prescription. You may be evaluated and/or treated for up to 10 visits or 30 days, whichever comes first. Please note that treatment under New York's Direct Access Law is not applicable to worker's compensation, no-fault, or Medicare coverage. I have been informed of the possibility that physical therapy treatment may not be covered by my health care insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

Treatment will begin on: _____
Date

I have received an electronic version of this document

Patient's Name: _____ Patient's Signature: _____ Date: _____

Address: _____

Physical Therapist Name: _____Therapist Signature: _____Date: _____

Better than before