CRALLÉ PHYSICIAL THERAPY SERVICES, P.A.

525 N. E. 3RD Avenue Suite 107 Delray Beach, FL 33444

NAME (PRINT)LAST_____ FIRST_____ Int._____

DATE OF BIRTH_____ GENDER: ☐ MALE ☐ FEMALE

SOCIAL SECURITY_____ EMAIL: _____
(IF APPLICABLE)

(local)
ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK _____CELL_____

(alternate)
ADDRESS_____CITY_____STATE_____ZIP_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ WIDOW ☐ DIVORCED ☐ SEPARATED

IN CASE OF EMERGENCY NOTIFY: _____ PHONE_____

Do you have a pacemaker? ☐YES ☐NO

RESPONSIBLE PARTY NAME_____ RELATIONSHIP_____
(IF NOT SELF)
PHONE_____

EMPLOYERS NAME_____ PHONE_____

ADDRESS_____CITY_____STATE_____ ZIP_____

PRIMARY INSURANCE_____ ID#_____

SECONDARY INSURANCE_____ ID#_____

REFERRING PHYSICIAN_____ PRIMARY PHYSICAN_____

REFERRED BY (other than physician) _____

IS CONDITION RELATED TO ACCIDENT?☐**YES** ☐**NO** DATE OF ACCIDENT_____ STATE_____

WHERE DID ACCIDENT OCCUR? HOME_____AUTO_____WORK_____ OTHER_____

EXPLAIN_____

_____ _____ _____

PATIENT/RESPONIBLE PARTY SIGNATURE **DATE** WITNESS

CRALLÉ PHYSICIAL THERAPY SERVICES, P.A.
525 N. E. 3RD Avenue Suite 107 Delray Beach, FL 33444

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Cralle Physical Therapy, P.A. of Delray Beach to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(Cralle Physical Therapy Services, P.A. Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Cralle Physical Therapy Services, P.A. reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Manager, Cralle Physical Therapy Services, P.A., 525 N.E. 3rd Avenue Suite 107 Delray Beach, FL 33444.

With this consent, Cralle Physical Therapy Services, P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items any calls pertaining to my clinical care including laboratory results. With this consent, Cralle Physical Therapy Services, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such appointment reminder cards and patient statement as long as they are marked Personal and Confidential. I have the right to request that Cralle Physical Therapy P.A. restrict how it uses or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Cralle Physical Therapy Services, P.A. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cralle Physical Therapy P.A. may decline to provide treatment to me.

_____ _____

Signature of Patient or legal Guardian **Date**

_____ _____

Patient's Name Name of Legal Guardian(if applicable)

CRALLÉ PHYSICIAL THERAPY SERVICES, P.A.
525 N. E. 3RD Avenue Suite 107 Delray Beach, FL 33444

AUTHORIZATION FOR FINANCIAL RESPONSIBILITY

I hereby authorize **Cralle Physical Therapy Services, P.A.** to furnish treatment to me

Patient Name:_____

I agree to pay for all fees for office visits at the time of treatment, unless other arrangements have been made.

I authorize Cralle Physical Therapy Services, P.A to release all medical and billing information to my appointed insurance company and/or attorney.

I authorize my insurance company to make payments directly to Cralle Physical Therapy Services, P.A., only if I have not paid my bill in full.

I certify that I will be financially responsible for any services given to me including, but not Limited to any and all insurance deductibles, denials or payment reductions that may occur on my account.

I agree to pay any and all services charges, collection agency fee, attorney's fees and court costs Encountered in the collection process.

I understand I have the right to request a summary of the Florida patient's bill of rights and responsibilities.

_____ _____ _____

Patient/Responsible Party Signature **Date** Witness

CRALLÉ PHYSICIAL THERAPY SERVICES, P.A.
525 N. E. 3RD Avenue Suite 107 Delray Beach, FL 33444

APPOINTMENT CANCELLATION POLICY

Dear Patient,

Cralle Physical Therapy strive to render excellent care to all our patients. In order to be consistent with this philosophy, we use an appointment system that sets aside time by scheduling with our front desk. When you do not notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit will be charged. Calling will make it possible to reschedule your appointment and allow us to provide care to others in need. When we experience a no show or a no call the following charges will be accessed:

- Myofascial: $240 per visit
- Normal visit: $200

We frequently have lists of needy patients who are waiting for treatment.

If we do not receive your message or if we have been provided incorrect information the cancellation policy will still be in effect. Questions regarding this policy can be brought to our staff. We thank you for your patronage. _____

I have read and understand the Appointment Cancellation Policy and agree to be bound by its terms. I also understand that this notice may be changed at any time by the practice.

Printed Name of the Patient:_____

Relationship to Patient (if patient is a minor) _____

Patient or Responsible Party Signature: _____ **Date:**_____