NorthStar Physical Therapy

Patient Information

Patient Name: _____ Date of Birth:_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave phone messages or text regarding your appointments? YES / NO

Email Address: _____ Email Reminders? YES / NO

Employer: _____ Occupation: _____

Employer Address: _____

Spouse or Legal Guardian Name (if under 18): _____

Emergency Contact: _____ Phone: _____

Medical Information

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Date of Injury/Onset of Symptoms: _____ Date of Surgery: _____

Injury due to an accident? YES / NO Fall? YES / NO IF YES: WORK / AUTO / OTHER: _____

If auto accident what state did it occur? _____ Diagnosis/ Body Part: _____

Billing Information

Primary Insurance: _____ Adjustor: _____

Phone: _____ Fax: _____

Address: _____

Policy ID: _____ Group/Claim #:_____

Name of Insured: _____Insured's Birthdate: ___/___/___ Male / Female

Insured's Address(if different from patient's): _____

Relationship to patient: _____ Insured's Employer: _____

Secondary Insurance: _____Phone: _____

Address:_____

Policy ID: _____ Group/Claim #: _____

Name of Insured: _____ Insured's Birthdate: ___/___/___ Male / Female

Who can we thank for referring you? (Please circle one)

Doctor, Friend, Family, Web search, Local Advertising, Phone book, Driving by, Other: _____

The above information is true to the best of my knowledge.

Signature: _____ Date: _____

Please read all of the information carefully prior to signing.

Consent for Treatment

I, the undersigned, do hereby agree and give consent to NorthStar Physical Therapy to perform a physical therapy evaluation and treatment techniques as required to appropriately rehabilitate my therapy related condition. I give NorthStar Physical Therapy my consent to use or disclose my health information to other health professionals in order to carry out my treatment when necessary.

Financial Agreement

- I authorize the release of all information, including medical records, necessary to process my insurance claims and for payment to be made directly to NorthStar Physical Therapy.
- I understand NorthStar Physical Therapy will submit my bill to my insurance or other third party payers but I am ultimately responsible for my payment of all account balances. I agree to pay all co-payments, deductibles, and percentages that my insurance doesn't pay and is my responsibility.
- If this account goes to collections, I will be responsible for all fees incurred.
- I understand a $5 monthly rebill charge is added to patient balances which are 60 days past due.
- I understand a $25 fee will be added for any returned checks.

Attendance Policy

- Individuals who NO CALL/ NO SHOW for their appointment may be assessed a $40 fee
- A total of three no-shows or cancelled appointments may result in discharge from therapy.
- We ask that you call as soon as you can to cancel any appointments; if necessary.

I have read the above information and understand my attendance and financial obligations.

Signature: _____ Date: _____

Notice of Privacy Practices

I acknowledge I have been given a copy of NorthStar Physical Therapy's Notice of Privacy Practice before signing this form. I understand the Privacy Practice and my rights as a patient.

Signature: _____ Date: _____