Holistic Physical Therapy LLC
149 Lincoln Ave, Monroe, MI 48162 Ph: 734.243.2089 Fax: 734.241.2275
HPTLLC@yahoo.com

Patient Information

Date:

Name:

DOB: Gender: SSN:

Address:

City: State: Zip:

Home Ph.: Work Ph.:

Cell Ph.: Preferred Contact No.:

E-Mail:

Occupation: Employer:

Driver's License No.:

Payment Method: ☐ Cash ☐ Check ☐ Charge ☐ Insurance

Is this injury related to: ☐ Work ☐ Auto Accident ☐ Overuse Date of Injury:

Worker's Comp. Rep.: Ph.:

Have you contacted a lawyer? ☐ Yes ☐ No Lawyer's Name:

Diagnosis:

Referred By Physician: Ph.:

Dr. ID No.:

Emergency Contact: Ph.:

Insured's Information

Address:

City: State: Zip:

Policy No.:

Insured's ID No.:

Insured's DOB:

Insurance Company Information

Insurance Co.:

Contact:

Address:

City: State: Zip:

Ph.: Fax:

Assignment of Insurance Benefits & Right of Recovery

In consideration of services rendered, I, ...
(patient) hereby irrevocably assign and transfer to Holistic Physical Therapy LLC (provider) all rights, title, and interest in the benefits payable for services rendered by this medical provider or practice provided in the above mentioned policy or policies of insurance or benefit and welfare plan benefits. Said irrevocable assignment and transfer shall be for the recovery on said policies of insurance or employee benefits plans, but shall not be construed to be an obligation on the part of this medical provider or practice to pursue any right or recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim, appeal claim denials, or sue for benefits individually should coverage be denied by any insurance carriers or employee benefit plan. I hereby authorize the insurance companies or employee benefit plans herein listed above to pay directly to this medical provider or practice all benefits due under said policy or plan by reason of services rendered. I will pay this medical provider or practice for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policies or plans. A copy of this authorization shall be considered as effective and valid as the original.

Designation of Authorized Representative – I hereby designate this medical provider or practice to act as my representative during an insurance or plan benefits appeal in the event of a coverage denial. I understand that this medical provider or practice has the right to decline or accept this designation at the time a denial is received. If this medical provider or practice accepts this designation, the outcome of any appeal is not guaranteed and I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan regardless of the outcome of any appeal. In the event my insurance company does not respond within 2 months of billing, and/or does not cover services provided by this establishment, I will be responsible for payment of the balance due in addition to any collection fees that may be assessed on this account.

....

Signature of Patient or Guardian — Date

....

Witness — Date

1st Week	$	4th Week	$	7th Week	$	10th Week	$
2nd Week	$	5th Week	$	8th Week	$	11th Week	$
3rd Week	$	6th Week	$	9th Week	$	12th Week	$

I Agree to the Above Terms

Signature of Patient or Guardian   Date

Physical Therapy Treatment Contract

I agree to attend all appointments scheduled for me and to participate in all aspects of the Physical Therapy treatment plan. This may include weekly instruction on the therapeutic exercise ball, aerobic exercise such as the Aerodyne bike, and Yoga instruction. I understand that these are all important aspects to my rehabilitation program. I understand that my personal involvement and commitment to my P.T. program is crucial to my over all success.

I agree to pay a $25 late, cancel, or no-show fee if I cancel less than 24 hours before my appointment time. If I cancel or no-show for more than 2 appointments I understand that I can be discharged from Physical Therapy at Holistic Physical Therapy. As a participant in the healing process I realize that keeping appointments will maintain the progress I make and missed appointments will cause delays in my progress. I understand that missed appointments have an effect on other patients who could have used that time in their own healing process.

I Agree to the Above Terms

Signature of Patient or Guardian   Date

Release Authority

To Whom it May Concern:
I hereby request that you release to:

Holistic Physical Therapy LLC
149 Lincoln Ave
Monroe, MI 48162-2606

Ph.: 734.243.2089
Fax: 734.241.2275

A complete copy of my records/test results as identified below:

	Date Performed	Where Performed	Address/City/State/Zip
CAT Scan			
MRI			
Myelogram			
EMG			
X-rays			
Bone Scan			
Lab Work			

I hereby authorize release of my medical information to Holistic Physical Therapy LLC

Patient (Print Name) Patient/Guardian Signature

Date of Birth

Witnessed By Date of Request

Holistic Physical Therapy LLC
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Patient Acknowledgement and Consent Form

Holistic Physical Therapy LLC
149 Lincoln Ave
Monroe, MI 48162
734.243.2089

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our notice of privacy practices. This Notice of Privacy Practices contains information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for disclosures in connection with: the defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as a part of a criminal investigation; an identification of a dead body; a license investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another physical therapist or other health care professional, or otherwise make disclosures of your information in connection with providing or coordination your treatment.

Please sign this form below under the heading "Patient Acknowledgement" to acknowledge that you have today received a copy of our Notice of Privacy Practices.

Patient Acknowledgement

Patient Signature: Date:

Patient Name (Printed):

For Office Use Only	
Patient Refused to Sign	
The following circumstances prohibit the patient from signing the Acknowledgement:	
An emergency situation prevented the patient from signing the Acknowledgement.	
Office Personnel (Signature)	Date:
Office Personnel (Print)	

Please sign this form under the heading "Patient Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

Patient Consent

I consent to disclosure of my health information in connection with my treatment.

Patient Signature: Date:

Patient Name (Printed):

How did you find Holistic Physical Therapy?

Please check all that apply:

- ☐ Recommended by a physician
- ☐ Through an Internet search
- ☐ Recommended by a friend or relative
- ☐ Saw an advertisement
  - Where did you see the ad?
    - ☐ On a Web site
    - ☐ Coffee News
    - ☐ FaceBook
    - ☐ LinkedIn
    - ☐ Yelp
    - ☐ Ad on pharmacy bag
    - ☐ Other
- ☐ Saw YouTube video
- ☐ Found through the HPT FaceBook page
- ☐ Found through LinkedIn
- ☐ Found on Yelp
- ☐ Other
  - Please specify: