PATIENT INFORMATION for TheraFit:

Name:_____
* (Last) (First) (MI)

Sex: M F Other preference _____ Age _____ DOB: ____/_____/_____

Cell Phone:_____ Home (Land Line):_____
Address _____
City_____ State _____ Zip _____

May we e-mail you with upcoming events: No Yes email address:_____

Employer _____ Occupation: _____
Employer Address _____ Emp. Phone:_____

In Case of Emergency _____ Phone:_____

Referring Physician's Name (if there is one): _____

Is there a Physician you want us to update on your therapy: Yes (go to next line) No

Physician Name:_____Clinic: _____

How did you hear about TheraFit: _____

I, the undersigned certify that all the above information is correct and I will inform the office of any changes as they occur.

Signature_____Date:_____
(Parent or legal guardian if minor)

PHYSICAL THERAPY at TheraFit:

Thank you for choosing TheraFit for your physical therapy needs. Please read the below information and sign or initial where indicated.

Contact Information:
I authorize contact from TheraFit to confirm appointments, treatments, health info & billing via:

Cell Phone Home Phone Text Email Work Phone

Appointments will be made using the Scheduling Software VAGARO with notifications via text/email and you will be entered in as a "Client" which can be then used for Pilates sessions as well if deemed appropriate for health and wellness plan.

Communication of Health Information:
Please List any other parties who can have access to your health information (This includes spouse, step parents, grandparents, family member, care takers/representative, health care providers that can have access to this patient's information)

Name: _____ Relationship:_____

Contact Phone: _____

Name: _____ Relationship:_____

Contact Phone: _____

PRIVACY POLICY:
Acknowledgement of receipt and understanding of privacy notice. I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I acknowledge that I have the right to receive a complete detailed copy of the NOTICE OF PRIVACY PRACTICES upon request. TFP has the right to change its Notice of Privacy Practices from time to time and that I may contact TFP at any time to obtain a current copy

_____

Please **print** your name Date Please **sign** your name

_____

Legal Representative Date Description of Authority

CONDITIONS / CONSENT FOR TREATMENT

I understand that in order for physical therapy treatment to be most effective, I must commit to the discussed plan of care and perform the home program created for my benefit. If I have any concerns with any part of my treatment program, I will discuss treatment options with my therapist before I consent to treatment.

I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

I waive TheraFit, LLC and Lisa Kolesar, DPT, OCS, ATC/L, of any and all liability related to the administration of unique hands-on treatment as well as movement prescription. By signing this document, I agree to the conditions stated in this form:

Patient/Guardian signature: _____ Date:_____

Print Patient name: _____

FINANCIAL POLICY
INITIAL EACH

_____ TheraFit, LLC (TFP) requires that all payment be paid at the time of service. By signing this agreement, I understand that TFP will not be billing my insurance and I understand that I am entering into care as a cash-pay client.

- _____ I understand that by choosing to be a cash-pay client at TFP I will not be submitting the Physical Therapy session(s) I receive at TFP toward benefits for Physical Therapy services to my health insurance provider for reimbursement or to satisfy any deductible/out of pocket limit I may be subject to under my health insurance plan.

- _____ I understand as a cash- pay client at TFP I will not be provided a superbill from TFP, nor will TFP submit any billing on my behalf to my health insurance provider.

    - _____However I may be provided proper documentation needed for submission to Health Savings Account(HSA) or Flex Spending Account (FSA). [Reimbursement is not guaranteed by my HSA/FSA provider and is according to their discretion.]

- _____ I know I have the right to seek Physical Therapy services from other providers who are willing to provide superbills for submission to, or will directly bill on my behalf, my insurance provider for reimbursement or to satisfy any deductible/out of pocket limit.

_____ I agree to pay TFP for all treatments at time of service, by cash or check, unless other mutually agreed upon arrangements have been made. A fee of $25 is charged on all returned checks.

_____ Failure to provide 24-hour notice of cancellation (via phone message, text message or email) or not showing for a scheduled appointment will result in a cancellation fee. I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel LESS than 24 hours in advance or No Show, I will be responsible for a **$75.00** fee for the first appointment, the second appointment will be charged as a full appointment and all fees will be payable in full **PRIOR** to my next appointment. If I no show/late cancel for a third appointment, I will be charged as a full appointment and all future appointments will be removed from the schedule and my name will be placed on a standby list allowing me to call the day I am able to attend and Therafit staff will check availability. This also applies to no-show appointments.

_____ I have freely chosen to cash-pay for services at TheraFit after having asked, and had all questions answered to my satisfaction, about payment options and having clearly considered these options.

_____

Please **print** your name Date Please **sign** your name