TaylorRehab
physical therapy
www.taylor-rehab.com

PATIENT INFORMATION FORM

Name: (Last)_____(First)_____(M.I).____SS#_____

Address: _____

City: _____State:_____ZipCode:_____

Phone:(Home)_____(Work)_____(Cell)_____

Sex: Male Female Birth Date: _____ Email: _____

Marital Status: Single Married Widowed Separated Divorced

Patient Occupation_____Employer:_____

Emergency Contact: Name: _____ Phone: _____

Referring Physician: _____ Date of Last Visit: _____

Body Part Being Treated: _____

Have you had any Home Health Care services?	YES/NO	Injured at work?	YES/NO
Have you had any Chiropractic services?	YES/NO	Related to Auto Accident?	YES/NO
Have you had surgery for this injury	YES/NO	Date of surgery _____	

Date of Injury/Onset of Illness: _____ Height:_____ Weight:_____

Current Medications: ☐ completed online

_____

_____

Medical History (please include surgeries, heart conditions, diabetes, etc): ☐ completed online

_____

Whom may we thank for this referral? : (i.e. Physician, friend, website, Google, Facebook, Social Media, etc.)

_____

I, the undersigned (or responsible party), certify that I have insurance coverage with and assign directly to Taylor Rehab Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. Less than 24 hour notice for cancellations may result in a fee which I am responsible for; in addition, a $25.00 fee will be charged for all "no shows. If your account is sent to our collection agency, in addition to paying 100% of your balance, you will also be charged up to 40% of the collection agency's fees as well as any reasonable attorney fees that may be charged. I hereby authorize Taylor Rehab to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party Relationship to Patient Date

114 Welton Way Suite B Mooresville NC 28117 704.660.6551 t 704.660.9894 f
167 Gateway Boulevard Mooresville NC 28117 704.658.1095 t 704.658.1097 f

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Taylor Rehab Inc.'s Notice of Patient Information Practices. I understand that Taylor Rehab Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payments, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Taylor Rehab Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.
I hereby consent to the use and disclosure of my personal health information for purposes as noted in Taylor Rehab Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
PATIENT SIGNATURE

_____ _____
PATIENT NAME **DATE**

If I choose to have my medical information communicated to individuals other than myself, I must do so by completing and signing the authorization form below.

I do hereby authorize Taylor Rehab to release my medical information to the person/persons listed below.

_____
NAME **RELATIONSHIP**

_____
NAME **RELATIONSHIP**

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

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TO OUR PATIENTS REGARDING CANCELLATIONS AND NO-SHOWS

Effective September 6, 2017, Taylor Rehab has updated our cancellation/no-show policy. Appointment times are reserved exclusively for you. If you are unable to keep your appointment, we request that you call at least 24 hours in advance to allow us to offer that time to another patient in need of treatment. Please keep in mind that not only you, but also our other patients and our staff are affected by your failure to keep appointments. Our primary goal is to help you get better. Your full participation is critical in helping you reach this goal.

The following charges will apply for cancellations and missed appointments (no-shows):

- Cancellations with less than 24 hour notice: $25.00
- Missed Appointment/No-Show: $25.00

These charges are not covered by health insurance benefits and are the responsibility of the patient/responsible party.

We realize that circumstances outside of your control arise on occasion and we will take this into consideration before assessing the $25.00 fee.

_____ _____

Patient/Patient Guardian Signature Date

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