



Welcome: _____

Please complete the enclosed paperwork and bring it with your **prescription** and **insurance cards** to your physical therapy appointment on _____

We request that you come in 10 minutes early so that we can complete your file and begin your therapy promptly. Also recommended is that you wear loose fitting clothing and either tennis shoes or walking shoes. These requests are for your safety and comfort during your therapy sessions.

If you know you will be unable to keep your scheduled appointment, please be informed that there is a 24 hour cancellation policy. Thank you for choosing Cambria Physical Therapy we look forward to helping you to recover your overall fitness and well-being.

Sincerely,

Sheri Baldwin, MS, PT
Melissa Sanden, DPT



PATIENT INFORMATION

Name: _____ D.O.B: _____ Age: _____ Sex: _____

Marital Status:(Please circle one) Single Married Widowed Divorced

Home Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

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

Email: _____ Social Security Number: _____

Spouse Name: _____ SS# _____ Date of Birth: _____

Referring Physician: _____ Primary Care: _____

Emergency Contact: _____ Relationship: _____

Phone: () _____

Primary Insurance: _____ **Secondary:** _____

Work Compensation Patients

Employer: _____ Address: _____

Phone : () _____ Supervisor: _____

Date of Injury: _____

Insurance Company: _____ Address: _____

Phone: () _____ Claim #: _____ Adjuster: _____

Revised 01/11



Appointment Agreement

A cancellation call is required at least 24 hours in advance in order to cancel or reschedule an appointment.

- I understand my failure to notify CPT will result in a **\$35 cancellation fee** that would be due by my next appointment.
- **If I am more than fifteen minutes late** for my appointment the therapist may be unable to treat me and may consider it a missed appointment. Illness will not count as a missed appointment.

FINANCIAL POLICY ASSIGNMENT

We bill your insurance company as a courtesy to you. We emphasize that your insurance coverage is based on a contract between you and your insurance company and it is your responsibility to pay any balances due if your insurance company does not cover your services. **If you are not insured and choose to pay privately it is your responsibility to pay amount in full at the time of service.**

Please inform us of any deductibles you have which have not been met and any co-pay requirements. Secondary insurances will be billed automatically. Statements are sent monthly regarding charges and payments on your account once insurance is processed.

I have read and agree to the above terms. I herein authorize my insurance company to make payments directly to Cambria Community Rehabilitation (CCR).

Signature of Patient/Guardian

Date