F & S PT	WELLNESS PT	WELLNESS PT	WALDRON PT
1414 Highway 71 N Alma, AR 72921 Ph (479) 632-0321 Fax (479) 632-0323	9501 Rogers Ave, #C Ft Smith, AR 72903 Ph (479) 484-1100 Fax (479) 484-1105	418 E Main Charleston, AR 72933 Ph (479) 965-0357 Fax (479) 965-0359	56 W. 2nd Street Waldron, AR 72958 Ph (479) 637-0744 Fax (479) 637-0755

PATIENT INFORMATION

Please present insurance card when registering.
Payment is expected at the time of service unless prior arrangements are made.

PATIENT INFORMATION

Name___________________________

Address ________________________

City ___________________________

State _________ Zip ____________

Phone _________________________

Cell Phone ______________________

___Receive text reminder

___Receive voice reminder

___No reminder

Date of Birth ____________________

SS# ____________________________

Height _______ Weight ______

PATIENT'S SPOUSE/GUARDIAN

Spouse/Guardian_______________

Relationship ___________________

Address _______________________

City __________________________

State _______ Zip ______________

Phone _________________________

Employer ______________________

Date Of Birth___________________

SS# ___________________________

Primary Insurance ______________________ Subscriber ID #___________________

Secondary Insurance _____________________ Subscriber ID #___________________

Referring Physician __________________________

Have you received any physical therapy this calendar year? __________________

Employer ____

Is this a Workers Comp Case? _______ If yes, Case Manager Information __________________

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges subject to coverage. I have been told about and understand the Notice of Privacy Practices.

_______________________________________ _______________________________

Signature of Patient Date

F&S / Wellness Physical Therapy

Patient Acknowledgement Form

______________ I agree and give my consent for F&S / Wellness Physical Therapy, Inc. to furnish me with medical care and treatments that are considered necessary and proper in diagnosing and/or treating my physical condition.

_______________ I understand that there is a copy of the Notice of Privacy Practices available for me to read. The HIPAA Privacy Notice describes the Practice's obligation to ensure the privacy of my health information. I know that I have the right to review the Practice HIPAA Privacy Notice and to ask for clarification. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of the HIPAA Privacy Notice.

______________ Auxiliary aids and services can be provided without cost upon request. A translator can be provided without cost upon request to communicate with your physical therapist.

______________ By signing this form I consent to the Practice use and disclosure of my health information for treatment, payment and healthcare operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken reliance on this consent.

______________ I understand that I will be subject to a **cancellation fee** of $25 if I do not call and cancel my appointment 24 hours before my scheduled time. I will also be subject to a $25 fee if I do not show up for my appointment (no show).

______________ I hereby assign all physical therapy benefits including Medicare private insurance and third party payers to F&S / Wellness Physical Therapy, Inc.

______________ I voluntarily refrain from wearing heavy **perfumes or colognes** to my appointment so as not to disrupt treatment for patients that are asthmatic or sensitive to strong scent. Therapy is given in a small area so for this same reason I also agree to **bathe** before my appointment. I understand that if I do not have access to a shower at home I can come to my appointment early and will be able to use the shower at this facility.

______________ I understand that there is a copy of the Senate Bill 277 available for me to read or take with me. It is my understanding that F&S/Wellness Physical Therapy, Inc will be collecting the **Primary Care Physician copay** and not the specialist copay that is often quoted while retrieving benefits. If my insurance company does not comply with Senate Bill 277, I will actively pursue this matter until my insurance company responds to this issue.

_____________ If you are a **shoulder patient**, wear a tank top so that the physical therapist is able to reach your shoulder without having you undress. If you are a **knee patient**, please wear shorts or sweats so that the physical therapist is able to reach your knee.

_______________________________________ ________________________

Signature of Patient or Patient's Representative Date