Steve Kravitz Physical Therapy
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(Please print. All information will be confidential)

Name: _____ Today's Date: _____
First Last

Birthdate: _____ Sex: M / F Age: _____ SS #: _____

Employer: _____ Occupation: _____

Referring Physician Name: _____ Phone # of Referring Physician: _____

Home Address: _____

E-mail Address:_____ Referred By:_____

Home #:_____ Cell #: _____

Insurance Co.: _____Insurance ID #:_____ Insurance Phone # _____

Emergency Contact: Name _____ Phone: _____ Relation: _____

1. What is the main reason for your visit today ? _____

2. Have you had any surgeries or hospitalizations in the past? (Y / N) If so, please describe and provide the year that the incident occurred:

_____

3. Please list any past or existing physical injuries or chronic illnesses/diseases. Please describe briefly:

_____

_____

4. What is your main goal for ongoing treatment? _____

_____

Financial Acknowledgement & ABN (Advance Beneficiary Notice of Non Coverage)

I understand that I am financially responsible for all charges on the day of each treatment whether or not these charges are covered under insurance. I hereby authorize the release of all information to secure payment. A minimum of 24 hours notice of cancellation is required and this office will be notified by 12:00 (noon) the day before any scheduled treatments if cancellation is necessary. Patient is responsible for payment for any missed or late cancellation of appointment (s) as described above. If payment is not made for any treatment or missed appointments, I authorize the use of my credit card on file for processing payment.

Furthermore, your signature below will acknowledge and consent that I will not be reimbursed through Medicare and this serves as an Advance Beneficiary Notice of Non Coverage (ABN). I agree that my physical therapy goals have been met and that the services I will receive at this practice will be considered a wellness visit. I also agree that these expenses will be considered out of pocket expenses and I will not be able to submit a receipt to Medicare for the visits at this office for reimbursement.

Signature: Patient / Guardian : _____ Date: _____