PATH
PHYSICAL THERAPY

CLIENT INFORMATION

Date: _____

Name: _____ Date of Birth: _____

Gender: _____ Email Address: _____

Mailing Address: _____

City/State/Zip: _____

Phone: _____ Referred By: _____

GUARANTOR INORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____

City/State/Zip: _____ Phone: _____

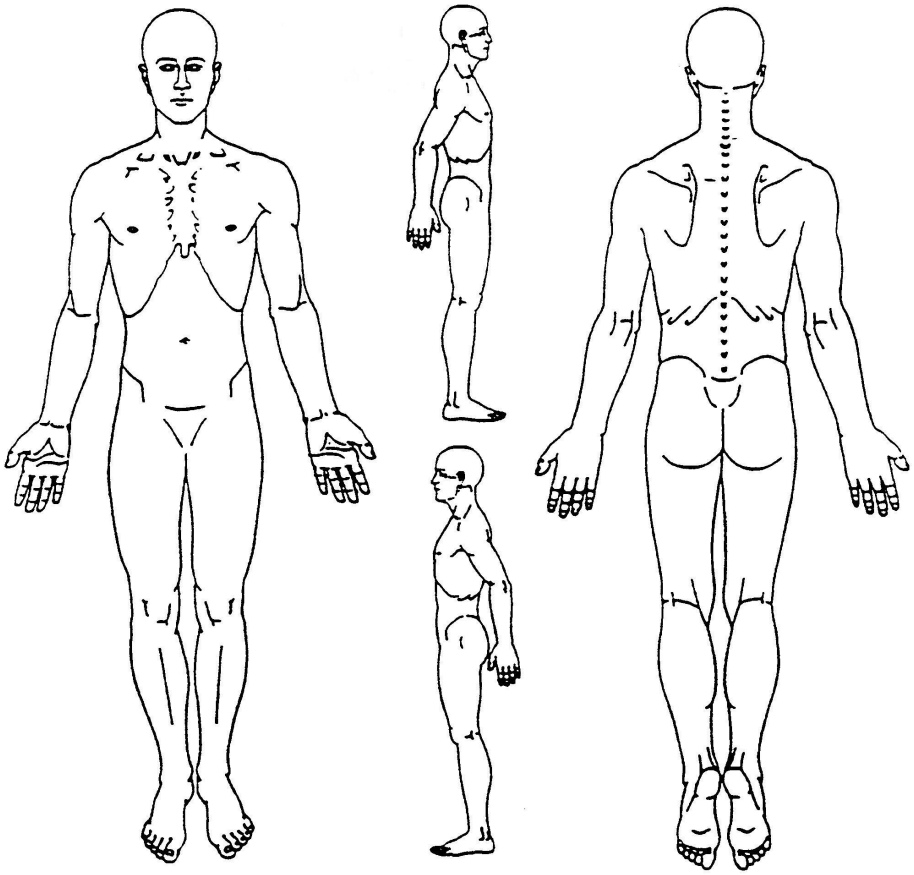
INSURANCE INFORMATION

- **We are an out of network provider**
- **We unfortunately do not accept workers compensation or no fault claims**

Insurance Company: _____ Member ID:_____

MEDICAL INFORMATION

Please circle the following areas that bring you in for treatment today:



Please list any of the following:

Recent Surgeries:	
Health Considerations:	
Allergies:	
Current Medications:	

EMERGENCY CONTACT INFORMATION

Contact Name: _____

Relationship: _____ Phone:_____

I give permission to Path/Kimberly Jolly LLC to contact this person in event of a medical emergency, and only for this purpose.

CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to physical therapy treatment provided by Path/Kimberly Jolly LLC, deemed medically necessary and proper in diagnosing or treating the client's condition.

Based on the information given by the therapist, I voluntarily consent and understand that I may withdraw or decline treatment at any time.

Client/Parent or Guardian: _____

Name: _____ Date: _____

PATIENT RESPONSIBILITY

Please Initial:

_____ I request the payment of benefits be made on my behalf to Kimberly Jolly LLC for any services rendered.

_____ I understand and acknowledge that submission of claims is not a guarantee of payment. If for any reason my carrier does not cover any/all of my costs of physical therapy treatment, I agree that I am responsible for the payment of the entire amount.

_____ I understand that it is my responsibility to obtain updated prescriptions from my provider at the end of the specified time given. If failure to do so, I understand that I will be responsible for payment of services not covered by my carrier.

_____ I understand that it is my responsibility to pay my bills in a reasonable time (no longer than 30 days from the date of service). If for any reason any portion of my bill us not paid, I understand that I am financially responsible for services rendered.

_____ I understand that if my insurance company makes payments directly to me for services rendered, I will remit the same payment to Kimberly Jolly LLC.

_____ I understand that it is my responsibility to notify Path/Kimberly Jolly LLC of any changes to my insurance carrier or coverage as soon as possible. Any failure to do so will result in the client being financially responsible for any lapse in coverage or authorization.

_____ I hereby authorize Path/Kimberly Jolly LLC to release all information necessary to secure payment of benefit. I authorize the use of this signature on all insurance submissions.

CANCELLATION POLICY

Please note that we have a 24 hour cancellation policy for all visits. If the appointment is not cancelled by 5pm the previous day, a $100 cancellation fee will be charged. By signing below, you have indicated that you understand the terms and conditions.

Responsible Party Name: _____ Signature: _____

Relationship to Client (if under 18): _____ Date: _____

HIPAA CONSENT FORM

I give Path/Kimberly Jolly LLC my consent to disclose my protected health information to carry out my treatment, to obtain payment from insurance companies.

I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and I may obtain any revised notices at the clinic.

I understand I have the right to request a restriction of how my protected health information is used.

I also understand that I may revoke this consent at any time, by making a written request, except for the information already used or disclosed.

With this consent, Path/Kimberly Jolly LLC may call and leave voicemails in reference to any items that assist the office in carrying out treatment, payment and operations such as appointment reminders, insurance items and clinical care.

Client/Guardian Signature: _____

Date:_____