Welcome to Evolve Physical Therapy and Sports. LLC. All questions contained in this questionnaire are confidential and will become part of your medical record.

DEMOGRAPHICS		
Name:		
DOB:	Age:	☐ M ☐ F
Street Address:		
City:	State:	Zip:
Contact Number:	Email:	
If a minor, name of guardian and relation:		
NOTIFY IN CASE OF EMERGENCY		
Name:	Relation:	Contact Number:
BILLING		
Guarantor:	DOB:	
Primary Insurance:	Member ID:	
Secondary Insurance:	Member ID:	
INJURY/SYMPTOMS		
What is your diagnosis or injured body part?		
Date of Injury/Onset of Symptoms:		
How did your injury occur?		
Is your injury work related? ☐ Yes ☐ No	If yes, was your injury reported to your employer? ☐ Yes ☐ No	
Physicians seen for this problem:		
Who can we Thank for referring you to our clinic?		
SURGICAL HISTORY		
Year and Name of Operation:		

PATIENT CONSENT

I agree that Evolve Physical Therapy and Sports, LLC may request and use my medical history and prescription medication history from other healthcare providers or third-party payors for treatment purposes. ☐ Yes ☐ No

PRIVACY NOTICE

I understand that a copy of Evolve Physical Therapy and Sports, LLC's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law is available upon request. ☐ Yes ☐ No

PHOTO/VIDEO RELEASE

I give permission to Evolve Physical Therapy and Sports, LLC to photograph and/or record video of me during treatment for use in clinic marketing, website content, and/or social media platforms. I understand I will not receive compensation for their use. I may revoke this permission in writing at any time for future content. ☐ Yes ☐ No

Signed _____

Date _____

Evolve Physical Therapy and Sports, LLC Financial Policy

INSURANCE

We'll verify your benefits for Outpatient Physical Therapy. Verification of benefits is not a guarantee of payment by the insurance company. As a courtesy, we'll bill your health, auto, or worker's compensation insurance company. If a problem arises, you may be asked to assist us by contacting your insurance company.

We'll gladly discuss your proposed treatment and will do our best to answer any questions related to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services based on your policies guidelines. At Evolve Physical Therapy and Sports, LLC our relationship and concerns are with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, all charges are your responsibility from the date services are rendered.

ACCOUNTS

Statements will be mailed monthly. We don't wait until the end of treatment to bill for amounts due. Any balance due is subject to change as visit dates process through your insurance. All balances due will be determined by the Explanation of Benefits (EOB) received from the insurance you provided to us. Any payments received in the office will be applied to your account. Payment is due within 30 days of receipt of your billing statement. Accounts with no payment activity after six months will be subject to collection efforts, including Bad Debt Status, which will prevent the scheduling of future appointments until the account balance is settled.

I've read Evolve Physical Therapy and Sports, LLC financial policy and agree to comply.
I'm responsible for any co-pay, co-insurance and/or deductible my insurance policy requires.

Patient Signature: _____ Date: _____

NO SHOW / CANCELLATIONS

Appointments missed with no notice will be assessed as $40 fee. Appointments cancelled day of or during non-business hours, such as on a Saturday or Sunday will be assessed a late cancel fee of $25. Evolve Physical Therapy and Sports, LLC will securely keep a card on file. If the card on file declines the transaction, you'll be billed for the charge on a monthly statement.

You may verbally give your card information to our office manager at the front desk or fill out the following:

Credit card number: _____

Expiration Date: _____ CVV_____

Name as it appears on card: _____

I understand that my card will be kept securely on file. If I no-show an appointment, my card on file will be charged a $40 fee. If I cancel day of or during non-business hours, such as a Saturday or Sunday, my card on file will be charged a $25 fee.

Patient Signature: _____ Date: _____