



**GOLDEN GATE
PHYSICAL
THERAPY**

Referring Physician _____

Secondary Referral Source _____

PATIENT INFORMATION

Date _____

Name _____
(First) (Last) (Middle Initial)

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____ Fax # _____

Social Security # _____ Sex M F Birth Date _____

Marital Status M S W D SO Spouse's Name _____

Emergency Contact Name _____ Emergency Contact # _____

Where did you hear about us? _____

Have you been treated at Golden Gate Physical Therapy before? Yes No

EMPLOYMENT INFORMATION

Employer/School _____ Occupation _____

Dept. _____ Address _____

City _____ State _____ Zip _____

Status Full-Time Part-Time Retired Disability Unemployed

MEDICAL INFORMATION

Referring Physician _____

Address _____ Phone _____ Fax _____

City _____ State _____ Zip _____

Date of Injury/ Surgery _____ Workers Comp Yes No

Auto Accident Yes No Lawsuit Yes No Employer _____

Attorney's Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Company Name _____

Name of Policy Holder _____ Relationship _____

Claims Address _____ Phone _____

Ins. Co. Phone _____ ID # _____ Group # _____

Secondary Insurance Company Name _____

Name of Policy Holder _____ Relationship _____

Claims Address _____ Phone _____

Ins. Co. Phone _____ ID # _____ Group # _____

WORKER'S COMPENSATION/ AUTO ACCIDENT

Insurance Company Name _____

Worker's Compensation is through: (Employers Name) _____

Claims Adjuster Name _____ Phone _____

Claims Address _____

Fax # _____ Claim # _____

Nurse Case Manager's Name _____ Phone _____ Fax # _____

GOLDEN GATE PHYSICAL THERAPY POLICY

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits as well as file therapy claims for you; however we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require **24-HOUR NOTICE** for any cancellation. A **\$50.00 fee** will be charged to your account for failure to comply.

TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent/ legal guardian for all minors.

Patient Signature Date _____

Parent or Guardian Signature / Print Full Name Date _____

Golden Gate Physical Therapy

KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. Please be aware to give 24 hours notice if you are unable to attend your appointment or it will result in a **\$50.00 charge.**

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and therapist have discussed the importance of frequency and duration.

THANK YOU FOR YOUR COOPERATION.

Patient Signature

Date