BIGHORN
PHYSICAL THERAPY AND SPORTS MEDICINE, P.C.

Name: _____ **Date of Birth:** _____ **Age:** ____ **Sex:** M F
Referring Physician:_____ **Diagnosis:** _____

Emergency Contact: _____ **Phone #:** _____

Patient Contact Information:

Street Address:

_____

City, State, Zip

_____

Mailing Address: (if different)

_____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Employer: _____
Email: _____

Insurance Information:
Insurance Company:

_____

Group Number:_____
ID Number:_____
Policy Holder's Information (if not the patient)
Name:_____
Policy Holder's Date of Birth: _____
Relationship to patient:_____

How did you hear about us? Physician Referral
Facebook Radio Newspaper Friend Family Website

Parent / Guardian Information: (If patient is a minor)
Name:_____ **Phone:**_____**Date of Birth:**_____
Address (City, State, Zip)**:**_____
Relationship to Patient:_____

Bighorn Physical Therapy and Sports Medicine respects your privacy as a patient. We will protect your medical information according to the Health Insurance Portability and Accountability Act (HIPPA).

I authorize Bighorn Physical Therapy and Sports Medicine to use my protected health information and to disclose my protected health information to my medical, pharmacy, dental, mental health providers, my insurance companies and to any state or federal agency that is assisting with the payment of my bill. This authorization includes, but is not limited to, my medical history, substance abuse, communicable diseases, mental health records, and billing information. Furthermore, I hereby designate Bighorn Physical Therapy and Sports Medicine as my lawful agent and assign to Bighorn Physical Therapy and Sports Medicine any benefits for medical services to which I may be entitled. I understand and agree: (1) the disclosure and use of my protected health information, to the entities referenced above, is at my request, (2) the information used or disclosed may be subject to re-disclosure by the individuals/entities receiving it, and would then no longer be protected by federal privacy regulations, (3) I may revoke this authorization by notifying Bighorn Physical Therapy and Sports Medicine, in writing, however, Bighorn Physical Therapy and Sports Medicine requires thirty (30) days to process any such request, (4) Bighorn Physical Therapy and Sports Medicine may use or disclose my protected health information until such time as I am no longer a patient at Bighorn Physical Therapy and Sports Medicine.

I consent to voluntary treatment of your condition with a physical therapist at Bighorn Physical Therapy and Sports Medicine.

I authorize Bighorn Physical Therapy and Sports Medicine to bill my insurance company. I understand that I am responsible for all amounts not paid by my insurance company. I understand that all co-pays are due at the time of treatment. I understand that if I default on my payment and collections are involved that I am responsible for all costs of the collections, including attorney fees, and these will be added to my account balance.

I understand that I am responsible for canceling my appointments at least 24 hours in advance. I understand that if I do not show up for my appointment without notification to cancel that I will be charged $25, and this is due at the time of my next physical therapy session. I understand that if I should “no show” for three straight scheduled physical therapy sessions then my chart will be discharged and I will be billed for the resulting charges.

Patient Signature:_____**Date:**_____
Parent / Guardian Signature (If patient is a minor)**:** _____