restore physical therapy 2607 South 159th Plaza, Omaha, NE 68130 (402) 933-7272 Date_____

Patient Information:

Patient Name:_____ Date Of Birth:_____ Age:_____ Sex:_____

Emergency Contact (Name/#)_____ Referring Physician:_____

Home Address: _____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____Employer:_____

NOTICE: We charge a $50 fee for any patients who fail to cancel or show up for a scheduled appointment. If you are unable to keep your appointment, please call us as soon as possible so we may fill that time with another patient. We appreciate your consideration. If you have had an automobile accident, you will be responsible for your bill through a cash pay basis. We do not file with auto insurance, so you will need to do so to receive any reimbursement from the responsible insurance/party.

Guarantor Information (Person Responsible for Bill)

Work Comp Injury Yes/No

Name: _____ Date Of Injury: _____

Claim #: _____ Case Worker's/Manager's Name: _____

Case Worker's/Manager's Phone Number: _____

Primary Insurance Information

Ins. Company:_____ Group #: _____Policy #:_____

Ins. Company Address:_____

Secondary Insurance Information

Ins. Company:_____ Group #: _____Policy #:_____

Ins. Company Address:_____

A. **Notice of Privacy Practices**. The policies and procedures of Restore Physical Therapy are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Privacy Notice of Restore Physical Therapy has been made available to me.
B. **Authorization to Treat**. I authorize and direct the medical practitioners of Restore Physical Therapy and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate. I understand that I have the right to receive information, to request treatment, and to seek a second opinion. Patients 18 years and younger must be accompanied by guardian.
C. **Assignment of Insurance Benefits.** I hereby assign all medical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Restore Physical Therapy. I understand that I am financially responsible for co-payments, co-insurance, deductibles, and any other balance not paid by my insurance plan.

The undersigned patient or patient's guardian hereby acknowledges to have read, understood and agreed to conditions set forth in the Notice of Privacy Practices, Authorization to Treat, Assignment of Insurance Benefits, and, if applicable, Medicare Patient's Information, and all applicable fees.

_____ _____

Signature of Patient or Legal Guardian (Employee Initials if consent written and sent with minor patient or obtained verbally) Date

_____ _____

Printed Name of Patient Date