Kathleen Eakins
Physical Therapy

Patient Information Sheet

Name _____
Address _____
_____
_____
Phone: Home_____Cell_____
Social Security # _____D.O.B. _____
Email Address _____
Employed By _____
Address _____
Phone _____
Emergency Contact:
Name _____ Phone _____

I authorize Kathleen Eakins to provide my physical therapy services. I have read and understood the patient privacy policy and will sign an authorization to use or disclose my health information when necessary. Initial _____

Self Payment Agreement

I agree to pay the full amount due for physical therapy services provided at the time of service. If payment is not received on date of service and prior arrangements have not been made, a late fee of $5 per week will be assessed.

Payment arrangements must be discussed and made in writing prior to the initiation of treatment.
Name [please print] _____
Signature _____Date _____

I authorize Kathleen Eakins to provide my physical therapy services. I have read and understood the patient privacy policy and will sign an authorization to use or disclose my health information when necessary. Initial _____

I agree to provide a 24 hour notice of cancellation for scheduled appointments or else a full session fee will be charged. Initial _____

Payment arrangements must be discussed and made in writing prior to the initiation of treatment.

Late payments will be assessed a $5 late fee.

Visit Fee Rate $85 per hour

2825 Marine Street, Suite 106, Boulder CO 80303

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Physical Therapy

Insurance Information

Insurance Carrier _____

ID# _____

Group # _____

If insured under spouse:

Spouse Name _____

Address _____

D.O.B. _____

Insurance Billing Address _____

Contact Phone Number _____

I have had previous physical therapy visits this year? Yes _____No _____

If yes, how many visits _____

I agree to provide a 24hour notice of cancellation for scheduled appointments or else a full session fee will be charged. This is NOT billable to the insurance company. Initial _____

I agree to have my Insurance Carrier billed for all physical therapy services provided, and agree to pay for all uncovered expenses, copays and patient portions as allowed by my insurance policy.

Signature _____Date _____

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