ONE POINT PHYSICAL THERAPY

867 Greenwood Ave NE
Atlanta, GA 30306
404-600-4627

PATIENT INFORMATION:

First Name: _____ MI: _____ Last: _____

Phone: _____ Work: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other Sex: ☐Male ☐Female

Social Security Number: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Email Address:_____

Would you like emailed appointment reminders? ☐Yes ☐No

How did you hear about us? ☐Doctor ☐Friend ☐Website ☐Attorney ☐Other

Employment Status: ☐Full time ☐Part Time ☐Other (please describe): _____

Employer: _____ Job Title: _____

Referring Provider: _____

Have you had any therapy in the past 12 months? ☐Yes ☐No

If yes, where and when?_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home/Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Insurance Company Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

ID#: _____ Group #: _____ W/C Claim #: _____

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐Employer ☐Other

Name of Insured: _____ Date of Birth: _____

Address:_____ City: _____ State: ____ Zip: _____

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Home Phone: _____ Work Phone: _____ SSN of Insured: _____

Employer of Insured: _____ Job Title: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Secondary Insurance Name: _____ Phone Number: _____

ID#: _____ Group #: _____

RELEASE AND ASSIGNMENT: I, the undersigned certify that I (or my dependent), have insurance coverage with the above listed insurance company and assign directly to OnePoint Physical Therapy, Inc. all insurance benefits. I understand that I am financially responsible for all charges that are not payable by insurance. There will be a 1% per month (12% annum) service charge posted to all accounts where no payment has been received. There will be a $30.00 returned check fee. **I understand that it is my responsibility to check with my insurance to see what my benefits will be and if my plan pays in or out of network. I realize that you have verified this, however, that is not a guarantee of benefits or payments**. I also authorize the release of my medical and billing information to my insurance company and Physician if requested to process this claim.

Patient Signature (if under 18, parent/guardian must sign) **Date**

Witnessed by **Date**

24-HOUR LATE CANCEL/NO SHOW POLICY: We have a 24-hour late cancellation/no show policy. If you fail to show up for your scheduled appointment you will be charged a $30.00 fee. Please call us 24 hours in advance to cancel/reschedule your appointment. Failure to do so will result in a $30.00 charge. This charge will be an out of pocket expense and cannot be billed to your insurance company.

Patient Signature (if under 18, parent/guardian must sign) **Date**

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