
New Patient Basics

Name _____ Date _____ DOB _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Email _____
Cell Phone _____ Home Phone _____
Emergency contact name _____ Relationship _____
Emergency contact phone number _____
Are you pregnant? _____

Insurance Information:

Sonia Chhabra Physical Therapy & Wellness is an out of network practice. This allows you to be in control of your health, and make decisions that are right for you. Some insurance plans may cover all or part of the services rendered. We can verify coverage, provide a detailed receipt, as well as, submit claims on your behalf. If you would like us to do that, kindly provide the following information:

Primary Insurance _____ ID# _____
Name of Primary Insured _____ DOB _____
EmployerName _____ Group# _____

Financial Responsibility:

In order to simplify the satisfaction of your fee per visit, Sonia Chhabra Physical Therapy & Wellness enables you to make your payments using a credit card. To facilitate processing and permit you to authorize payments via phone, kindly sign below so we can maintain your signature on file. If you do not choose to leave your credit card information on file, simply sign to acknowledge understanding that full payment is due at, or prior to, date of service rendered.

Patient Signature _____ **Date** _____

Credit Card Type _____ Credit Card# _____
Expiration Date _____ Security Code _____ BillingZip _____

I attest, to the best of my knowledge, that the above information is accurate and true.

Patient Signature _____ **Date** _____

Authorizations & Acknowledgements

Treatment Authorization: I, (print name) _____, authorize physical therapy treatments of myself or my minor child by the Therapist at Sonia Chhabra Physical Therapy & Wellness.

Informed Consent: At Sonia Chhabra Physical Therapy & Wellness, we use a variety of procedures and modalities to better your health. As with all forms of medical treatment, there are benefits and risks involved with Physical Therapy. Since response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. You have the right to ask your Physical Therapist about your treatment and/or treatment plan. You may also discuss with your therapist what the potential benefits or risks may be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most Physical Therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

Medical Doctor: Sonia Chhabra Physical Therapy & Wellness believes your doctor is a vital part of your health care team. As such, upon your request, we will send evaluations and progress reports to the physician listed below.

Name of MD _____ **Specialty** _____

Address _____

City _____ **Zip** _____ **Phone** _____

Cancellation/No-Show Policy: Last minute cancellations take away the possibility for another patient in need to receive care. We request 24 hours notice for all cancellations. In the event 24 hour notice is not given, you will be subject to a \$150.00 charge. If you simply are not present for a confirmed appointment, you will be subject to a \$250.00 charge.

No Guarantees: The practice of Physical Therapy is as much an art as it is a science, therefore, you acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes of any therapy rendered.

Patient Acknowledgement: By signing and dating this form, I acknowledge that I agree with and am comfortable with the information presented above, I consent to the Physical therapy treatments offered, and I intend this consent to apply to all my present and future Physical Therapy care at Sonia Chhabra Physical Therapy & Wellness.

Patient Signature _____ **Date** _____

Print Name _____