

SPORTS MEDICINE AND REHABILITATION THERAPY, INC.

PHYSICAL THERAPY

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MALDEN, MA 02148
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FAX: (781) 397-6752

328 MAIN STREET
READING, MA 01867-3618
(781) 944-5246
FAX: (781) 944-6686

PLEASE PRINT AND SUPPLY ALL INFORMATION

NAME: _____ **DATE OF BIRTH:** ___ / ___ / ___
 First **M.I.** **Last**

ADDRESS: _____ **SEX:** _____
 Street **City** **State** **Zip**

PHONE: (____) _____ **SOCIAL SECURITY #:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **PHONE:** (____) _____
 Street **City** **State** **Zip**

GUARANTOR OF PAYMENT: _____ **PHONE:** (____) _____

SOCIAL SECURITY #: _____ **ADDRESS:** _____

IS YOUR INJURY: **WORK RELATED** _____ **AUTO ACCIDENT** _____ **OTHER** _____

DATE OF INJURY: _____ **FOLLOW UP WITH M.D.** _____

PLEASE READ THIS SECTION:

Twenty-four (24) hours notice is required on all cancellations. If the patient is scheduled for an appointment and he/she does not call to cancel 24 hours prior to appointment time or he/she does not show up, there will be a \$20.00 charge for the missed visit. This fee must be paid at the time of the next appointment.

All co-payments are due at the time of visit. It is the patients responsibility to know if a co-payment is required by their insurance and the amount of that co-payment. S.M.A.R.T. will not be responsible for ensuring collection of these payments and reserves the right to bill at a later date if the co-payments are not made at the time of the visit.

It is the patient's responsibility, not the responsibility of S.M.A.R.T., to verify coverage for physical therapy services with their insurance company.

If information for submission of claims is not provided, the bill for services will be the patients responsibility.

I have read the above policies and understand their content.

SIGNATURE OF PATIENT OR PARENTAL/LEGAL GUARDIAN **DATE:** _____