PACRAV

PHYSICAL THERAPY . RENO . NV

Please complete ALL of this section

Name:_____ *(If Minor)* Parent/Legal Guardian:_____

Social Security #_____ DOB:_____/_____/_____

If patient is not the subscriber on insurance: Subscriber Name:_____DOB:___/___/___

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

1st Appt. Date:_____ Home Ph # ( )_____ Cell Ph # ( )_____

Appt. Reminders Via: Home Ph____ Cell Ph____ (call___, text_____)

E-Mail_____ No Reminders_____

Please print clearly

Employer:_____ Phone: ( )_____ Can we contact you at work? Yes ___ No ___

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

Emergency Contact_____ Ph ( )_____ Relationship:_____

APPOINTMENTS: We schedule our patients so that we have adequate time to give you the personal attention that you require. We make every attempt to remain on time, however, there are times when extra time is needed with a patient due to special problems or to allow us to communicate with other providers. If you are kept waiting we will not deduct from your treatment time. Please note the following:

- Failure to arrive within 15 minutes of your scheduled appointment may result in our inability to provide services to you that day.
- We request notice by **10am the day before** your scheduled appointment for cancellations. Messages may be left on our voicemail during non business hours.
- We request notice by **10am <u>two</u> business days** ahead of your scheduled appointment for hour long appointments.
- Monday appointments must be cancelled by **Friday before 10am**.
- Automated reminders are a courtesy. Not receiving a reminder does not excuse you from our appointment policy.

<u>If you late cancel or no-show two appointments you will not be rescheduled.</u>

SCHEDULING: You are responsible for scheduling your own appointments with our staff. Please discuss with your therapist the number of times you should schedule per week and schedule as far in advance as possible in order to obtain the most convenient appointment times.

☐ ***I have read and understand the appointment policy.***

I authorize PACRAV Physical Therapy to release and/or request information to/from insurance companies abd all medical providers. I authorize assignment of benefits be paid directly to PACRAV Physical Therapy

X **Signed by:**_____ **Date:**_____

Patient/Guardian Signature