Arnold Physical Therapy, P.C.

PATIENT REGISTRATION

Date:______________________________

Patient's Name: ______________________________(Preferred)__________________

If patient is a minor parents name:____

Social Security #:____________________DOB:____/____/____Age:_____Gender:_____
(only if Tricare or Workers' Comp)

Physical Address:____
City:______________State:________ Zip:________

Mailing Address: ____
City:______________State:________ Zip:________

Phone:(Home)________________(Cell)__________________(Work)________________

Employer:____________________________Occupation:____________________
City:______________State:________ Zip:________

Spouses Name:____________________________Phone No.:________________

Referring Physician: ____

Primary Care Physician:____

CANCELLATION AND NO SHOW POLICY

Arnold Physical Therapy stresses patient compliance to facilitate achieving patient and physical therapy goals. A **24-hour notice** is appreciated for all cancellations. **More than three (3) cancellations including no shows** will terminate further scheduling of physical therapy appointments. A letter will be sent to your referring physician. Individual extenuating circumstances will be considered and reviewed by the managing physical therapist, Michael J. Arnold. A high cancellation rate and extended waiting period for new patients needing prompt physical therapy services dictates this policy.

I agree to and understand this policy.

Signature:____________________________________Date: ________________