171 S. Lake Ave.
P.O. Box 206
Phillips, WI 54555

sPorT plus physical therapy, LLC

"Specializing in Patient Oriented Rehabilitative Treatment"

Mel Eggebrecht, DPT

P (715) 339-6140
F (888) 412-1366

Demographic Form

Chart # _____

APPOINTMENT INFORMATION

1. Please be on time for your appointment – If you are more than 10 minutes late, you may be asked to reschedule, as therapy is prescribed for the allotted time scheduled.
2. If you do not show up for 3 of your scheduled appointments without a call and cancellation or reschedule, your skilled physical therapy may be discontinued due to non-compliance.
3. Please wear appropriate clothing for exercise. Shorts and a tee shirt or similar loose fitting clothing are suggested for your exercise sessions.

PERSONAL INFORMATION

First Name	What you prefer to be called	MI	Last Name	Sex M / F	DOB / /
Home Telephone # ( )	Best Contact Telephone # ( )	Marital Status (Please circle one) Married Single Divorced Widow			
Address (Street)	PO Box	City	State	Zip Code	
Emergency Contact Name	Emergency Contact Telephone # ( )	Relationship to Patient			
Current Employer	Employer Telephone # ( )	Current Work Status (Circle One) Full-Time Part-Time Not Applicable			
Work Related Injury : Yes No	Date of Injury: / /	Employer at time of injury:			
If Patient is a Minor: Father's Name	Father's Phone #	Name of Parent who should receive statement			
Mother's Name	Mother's Phone #	Insured Parent's Address			

Whom may we thank for the referral? _____

How did you find out about sPorT plus physical therapy, LLC? _____

Who is your Primary Care Physician (regular doctor)? _____

ACKNOWLEDGMENT OF sPorT plus physical therapy PRIVACY POLICY *and* FINANCIAL POLICY–

I have reviewed and/or been given an opportunity to request a copy of the Notice of Privacy Practices and/or Financial Policy from sPorT plus physical therapy, LLC and understand the information as outlined. ***I understand charges not covered by the payer source at the time of my therapy services become my responsibility to pay in full.*** By signing I agree to the above statements and verify that the above information is accurate to the best of my knowledge.

_____
(Name of Patient – Please Print)

_____
(Signature of Patient) **(Date)**

_____
(Signature of Parent/Legal Guardian if patient is under 18 years old) (Relationship to Patient)

***It is <u>your</u> responsibility as the patient to call your insurance company and verify therapy providers in your insurance plan, and physical therapy benefits, as they may be different from those of the referring doctor.**