



PHYSICAL THERAPY / WELLNESS / TENNIS

LEGENDARY HEIGHTS Patient Registration Form

Legal Name:
(Last) (First) (Middle)

Preferred Name: DOB: Age:

E-mail:

Phone(s) Home: Cell: Work:

Home Address:
(Street, City, State, Zip)

Gender: Male / Female Marital Status: Single / Married / Divorced / Widow

SS#: Primary Care Provider (PCP):

PCP Phone Number: PCP Work Address:

Emergency Contact / Legal Guardian

Name: Phone Number:

Relationship to Patient:

How did you hear about my physical therapy services?

Former patient / Physician Referral / Friend / Family Referral / Other:

HIPPA / Privacy Policies / Cancellation / Consent to Treat

Patient Privacy Practices
(Initial)

Ensuring your Protected Health Information (PHI) is very important and will remain confidential. Your paper and electronic medical records are safeguarded and will only be released with your consent to other medical professionals directly involved with your care, or when/as required by law. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records, except as authorized



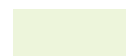
in this document. By initialing above, you verify that you understand the above statement and information.

 Release of Medical Information Authorization:
(Initials)

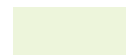
I give Dr. Danrich Kruger PT, DPT authorization for the release of “Medical Records/Privacy Information”, which includes but is not limited to your PHI, medical conditions, and billing information to the following individual(s):

Name:  Relationship to Patient: 

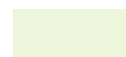
Name:  Relationship to Patient: 

 24-hour cancellation and No- Show Fee Policies
(Initial)

Each time a patient misses or cancels an appointment within a few days of his/her visit without providing proper notice, another patient is denied and prevented from receiving patient care. Therefore, 100% of the patient’s treatment session will be charged for cancellations within 24 hours prior to the treatment session or for not showing up to their scheduled treatment session. For compelling reasons only will leniency be applied. I understand this policy and that the dollar amount will be owed by me and must be paid prior to the next treatment session. By initialing above, you verify that you understand the above statement and information.

 Disclosure of Financial Interest
(Initials)

In certain situations, the highest quality of care that may be deemed as a necessity to you might be financially beneficial to your therapist. All treatments are intended to serve patients with the best quality of care and to provide clinical excellence in a safe and attractive environment for you and your family members. Any financial gain that can be linked to the therapist will be disclosed beforehand. Should you have any concerns regarding the specific plan of care that might benefit the therapist, please feel free to ask and discuss this with your therapist. By initialing above, you verify that you understand the above statement and information.

 Consent of Treatment:
(Initials)

I authorize Dr. Danrich Kruger PT, DPT to evaluate and treat me or my family member for any sports, orthopedic illness, or other injury for which I seek medical care. I have read and understood the above as well as all other document signed and further acknowledge that I accept the terms outlined in each of the documents/policies noted above.



[Redacted] Confidential Text and Email Authorization
(Initials)

I give permission to receive emails about appointments, bills, or, when applicable, other information I may request.

Email: [Redacted]

I acknowledged that I have read and understand the "Patient Privacy Practices", "HIPAA and Release of Information", "Consent of Treatment", and "Cancellation / No-Show Policy". I understand and accept the terms outlined in each of these policies.

[Redacted]
Signature of Patient / Parent / Legal Guardian

[Redacted]
Date

