9061 E Frontage Rd
Palmer, Alaska 99645

Recovery Waters
PHYSICAL THERAPY

Phone: 907-795-4255
Fax: 907-802-6559

Patient Demographics

Patient Information	
Name: _____	Gender: _____
Address: _____	Date of Birth: _____
City, State, Zip code: _____	Social Security #: _____
Home Phone: _____	Marital Status: _____
Cell Phone: _____	Spouse Name: _____
Email: _____	Spouse DOB: _____

Patient Employment Information	Emergency Contact
Business Name: _____	Name: _____
Address: _____	Relationship to Patient: _____
Phone: _____	Phone: _____

Responsible Party (if under 18)	
Name: _____	Relationship to Patient: _____
Mailing Address: _____	Date of Birth: _____
City, State, Zip: _____	Phone:_____

Primary Insurance	Secondary Insurance
Insurance Name: _____	Insurance Name: _____
Policy/ID #: _____	Policy/ID #: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Date of Birth: _____	Policy Holder's Date of Birth: _____
Policy Holder's Phone Number:_____	Policy Holder's Phone Number:_____
Relationship to Patient: _____	Relationship to Patient: _____

Tertiary Insurance	
Insurance Name: _____	Policy Holder's Date of Birth: _____
Policy/ID#: _____	Policy Holder's Phone Number: _____
Policy Holder's Name: _____	Relationship to Patient: _____

frontdesk@recoverywaterspt.com

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How would you like to receive appointment reminders?		
○ Call: _____	○ Text: _____	○ Email_____

CONSENT TO TREAT

I authorize Recovery Waters Physical Therapy to examine me, administer treatment and supply durable medical equipment as necessary, and perform procedures that are considered therapeutically or diagnostically necessary.

Signature: _____ Date: _____

Relationship to Patient: _____

RELEASE OF INFORMATION

I authorize the release of information to the following individuals. I understand that only the individuals listed below will be able to obtain information regarding myself (including date and time of appointments).

_____ _____

_____

_____

Initial Below for any of the following durable medical equipment companies:

_____ Arctoa Medical

_____ Tactile Medical

INSURANCE NOTIFICATION

Services provided by Recovery Waters Physical Therapy are payable at the time of service. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company, and although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf.

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company. It is also your responsibility to notify us if your insurance changes or terminates. You will be responsible for any unpaid services. If you have additional questions, you will need to speak to someone prior to your appointment or contact your insurance company directly for all specific plan benefit information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Recovery Waters Physical Therapy's Notice of Privacy Practices. This notice describes how Recovery Waters Physical Therapy may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information. I am aware and agree that Recovery Waters Physical Therapy may use or disclose my health information for research purposes under certain limited circumstances, and that in the event that my medical records are requested by a third party, I or my appointed legal guardian, must sign a medical release form in order to distribute that information.

By signing below, I am acknowledging that I have read, understood, and agree to the Release of Information, Insurance Notification, and the Notice of Privacy Practices.

_____ _____

Signature Patient/Guardian Date