MOBILITY FIT
PHYSICAL THERAPY

WOMEN'S HEALTH ~ CLIENT DEMOGRAPHICS

DEMOGRAPHICS

First Name_____ Last Name_____ MI_____

DOB____/____/____ Cell Number_____ Alt. Number_____

Address_____ City_____ State_____ ZIP Code_____

Social Security Number_____ Email Address_____

How did you hear about us?_____

EMPLOYMENT INFORMATION

Occupation_____

Employer_____Employer Phone Number_____

INSURANCE INFORMATION

Person Responsible for Payment (Subscriber)_____ DOB____/____/____

Address (If Different)_____ City_____ State____ ZIP Code_____

Cell Number_____ Social Security Number_____

Name of Insurance Provider_____ ID Number (As Appears on Card)_____

Group Number_____

EMERGENCY CONTACT INFO

Name of Contact_____ Relationship to Client_____

Cell Number_____ Home Number_____

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the Mobility Fit Physical Therapy, LLC. I understand that I am financially responsible for any balance. I authorize MOBILITY FIT PHYSICAL THERAPY LLC or insurance company to release any information required to process my claims.

Client/Guardian Signature_____ Date____/____/____

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OME ' E LT - Cancellation & no-show policy

Our goal is to provide a physical therapy experience far superior to any you have previously known or experienced. This means that you will be scheduling one-on-one sessions with one of our doctors of physical therapy. Each and every appointment space is important; therefore our no-show and late cancellation policies are in place in order to maximize the available offerings for our clients.

EFFECTIVE JULY 1, 2018

Cancellation Policy & No-Show Policy:

With the high demand for available slots, we require 24-hours advanced notice to cancel an appointment.

- Cancellations or a no-show with less than 24-hours notice will receive a charge to their account, as follows:
  - **$50 per appointment**
  - **Multiple late cancellations or no-shows may result is termination from therapy at Mobility Fit's discretion.**

Late Arrival Policy:

We value each and every one of our clients and we desire for everyone to receive the same high-level of care at each and every visit.

- **In order to ensure this high-level of care, should you arrive 15 minutes or later from your scheduled start time, we will need to reschedule that appointment for another day and a late cancellation fee may apply. Our Client Coordinators will reach out to you after 10 minutes to determine how to proceed.**

By signing below, I understand that should I no-show, late cancel, or arrive late my account will either be charged or payment will be collected at my next visit. I understand that this policy is to encourage my dedication to the process and to ensure success for all.

Client Signature: _____ Date: ____/____/____