PRIVATE THERAPY SERVICES
PTS
PHYSICAL THERAPY & SPORTS MEDICINE CENTER

Locations

West Ashley
445 Savannah Hwy,
Charleston SC 29407

Mt Pleasant
1300 Hospital Drive Suite 360,
Mt Pleasant SC 29464

Aquatic Center
780 West Oak Forest Drive,
Charleston SC 29407
(WL Stephens Aquatic Center)

Office: 843-766-2121/ Fax: 843-766-8644

First Name_____ **Middle**_____ **Last**_____

Address_____

City_____ **State**_____ **ZIP**_____

Phone (H):_____ **(W):**_____ **(Cell):**_____

SS#_____ **Date of Birth**_____ **( ) Male ( ) Female**

Employer_____ **Email:**_____

Marital Status: Married ( ) Single ( ) Divorced ( ) Other ( ) Spouse_____

In case of emergency contact: _____ **Relationship:** _____

Phone: _____ **Alternate Phone:** _____

Referring Physician: _____ **Primary Care Physician**_____

Reason for Physical Therapy: _____

How did you hear about us? _____

Notifications

Check the appropriate box if you would like to receive automatic notifications of upcoming appointments

- **Notify by email**_____
- **Notify by text/ phone#**_____

CURRENT HEALTH INSURANCE INFORMATION

(I understand that it is my responsibility to know my current health insurance coverage and that PTS is not responsible for providing this information.)

I have verified my PT insurance coverage: ( ) Yes ( ) No

Copy of Current Card Provided ( ) Yes ( ) No

Insurance Information

Primary Insurance: _____ Policy#_____

Claims Address:_____ Group#_____

Policy Holder's Name:_____ DOB:_____ Relationship:_____

Deductible Remaining: $_____ Copay: $_____ Coinsurance:_____

# of PT visits/dollar amount allowed: _____ Does this policy require pre-authorization? _____

Secondary Insurance: _____ Policy#_____

Claims Address: _____ _____ Group#_____

Policy Holder's Name:_____ DOB:_____ Relationship:_____

Deductible Remaining: $_____ Copay: $_____ Coinsurance:_____

# of PT visits/dollar amt allowed:_____ Does this policy require pre-authorization?_____

Is this a supplemental policy? _____

Combined Authorizations:
I authorize physical therapy treatment as prescribed by my physician. I certify that no guarantee or assurance has been made as to the insurance coverage or results that may be obtained. I authorize the release of any medical information needed to process my insurance claims. I authorize all insurance benefits to be paid directly to Private Therapy Services. I give my permission for Private Therapy Services to call and leave messages on my home phone, work and cell phone and speak with anyone whom might answer. I attest a Notice of Information Practices (Medical Records Privacy Policy) has been provided to me, as required by HIPPA regulations. I hereby certify that I read and fully understand the above authorizations.

Signed: _____ Date: _____

*If minor, signed by Mother ( ) Father ( ) Guardian ( ) Other ( ) Name_____

Please list your Availability for future appointments:

Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____
