The Gait Center

LAWRENCE REHABILITATION

Registration

Full Name (first, middle, last): _____

Date of Birth _____/_____/_____ Phone: _____ Work or Cell: _____

Email: _____

Address:_____

City: _____ State: _____ Zipcode:_____

Sex: M or F Marital Status: S M D W Other Student: Y or N School: _____

In Case of Emergency Please Contact: _____

Phone#: _____

Primary Insurance Company: _____ Subscriber ID: _____

Policy Holder: (if different than patient) _____ Date of Birth _____/_____/_____

Relation to Patient:_____ Address: _____

City: _____ State: _____ Zipcode:_____

Secondary Insurance: _____ Subscriber ID: _____

Policy Holder: (if different than patient) _____ Date of Birth _____/_____/_____

Reminder Notifications: Automated reminders will be sent 24 hours in advance of your appointment.
Please Select One:

☐ **TEXT – Cell Phone** ☐ **CALL - Cell Phone** ☐ **CALL - Home Phone** ☐ **No Reminder**

Attendance Policy

- A cancelled visit will be recorded if the Gait Center receives notification at least 24 hours in advance of appointment. There is no charge for cancelled visits.
- Notification less than 24 hours will be considered a missed visit. After 2 missed visits the patient will be charged a $35 fee for each additional missed visit. This amount will be due at the next scheduled visit.
- More than 6 cancellations or missed visits will be cause for review of the rehabilitation commitment and possible discharge from physical therapy services at The Gait Center.

By signing below, I acknowledge that all of the above information is true and accurate and I agree to the Attendance Policy. If at any time any of this information changes, I am aware that I must inform the office immediately to avoid unnecessary patient balances.

Patient/Parent/Guardian Signature: _____ **Date:** _____/_____/_____

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