 **PHYSICAL THERAPY FOR ALL**

***Rehabilitation services and equipment for those in need***

**PHYSICAL THERAPY REFERRAL FORM**

**To refer a patient to Physical Therapy through Physical Therapy For All:**

**send this form, the Patient Liability Release, the most recent patient visit notes and any**

**imaging reports to** [**Barbara@ptforall.org**](mailto:Barbara@ptforall.org) **or fax (509) 461-2264.**

**For additional assistance call (949) 735-9955.**

**REFERRING CLINIC INFORMATION**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CLINIC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT PERSON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PATIENT INFORMATION**

**Name of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_M \_\_\_\_\_\_F**

**Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If child, name of parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does patient speak English? \_\_\_\_\_\_ Patient’s preferred language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does patient have insurance? \_\_\_\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**REFERRING PHYSICIAN INFORMATION**

**Referring MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***“All persons, regardless of their economic status, receive medically necessary physical therapy services & equipment”***

**A 501(c)(3) nonprofit public charity California Attorney General’s Registry of Charitable Trusts: CT0207705**

**PTFORALL.org 31022 Via Mirador San Juan Capistrano, CA 92675 949.735.9955** 01282018

** PT SERVICES PATIENT LIABILITY RELEASE**

If I am accepted into the PT Services Program, I acknowledge and accept full responsibility for the physical therapy care that I receive at a clinic that has partnered with PTFORALL.

I understand the following to be true:

1. PTFORALL makes no guarantees about the quality of physical therapy services that I may receive.
2. I have the right to stop physical therapy at any time for any reason.
3. PTFORALL will only pay for physical therapy services at clinics on our list of physical therapy service providers.
4. If I am unable to attend an appointment, I will be courteous and call the physical therapy clinic to cancel, as there is no penalty for cancelling 24 hours ahead of time.  If I do not, I am responsible for any fees the PT clinic charges for late cancellations and “no shows”.
5. I will be dropped from the program for one “no show” or two late cancellations.
6. The physical therapy office where I receive my care will send their PT treatment notes regarding my care, along with the bill for PT services, to PTFORALL. This is to ensure that PTFORALL is only paying for treatments delivered by a licensed PT or PTA and to verify that I am receiving good care.
7. PTFORALL has no ownership interests in any of the physical therapy clinics or rehabilitation centers listed on our website.
8. I must contact PTFORALL immediately if I am not satisfied with my care:

Barbara Gray 949.735.9955 [barbara@ptforall.org](mailto:barbara@ptforall.org)

I hereby release, discharge, and covenant not to sue PTFORALL, its officers, board of directors, volunteers and employees (each of the forgoing shall be considered one of the releasees herein) from all liability, claims, demands, losses, or damages related to any injuries, pain, suffering or adverse outcomes I may sustain while receiving physical therapy care under this PT Services Program at a clinic that has partnered with PTFORALL, and agree to hold harmless each of the releasees from any litigation expenses, attorney fees, loss, liability, damage, or cost which may be incurred as the result of such claim.

**I acknowledge that I have read this agreement** and fully understand its terms, have signed it freely, and have voluntarily entered into this agreement at my own risk.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print full name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_

Signature of applicant

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