Bodies In Motion Physical Therapy

Patient Information

Last Name	First	MI	Date of Birth	Social Security Number

Home Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

E-mail Address:

Employer Name & Occupation — Marital Status: S M D

Referring Physician Information

Name — Phone

Is this injury or illness the result of a work or auto accident? Yes No
Have you had physical therapy previously this calendar year? Yes No
Where did you hear about Bodies In Motion ?_____

Emergency Contact/ Legal Guardian Information

Last Name	First	Phone	Relationship

Insurance

Primary Insurance Co. — Policy No.

Name of Insured — DOB: — Relationship to Insured

Secondary Insurance Co — Policy No.

Have you recently had Physical Therapy in a HOME HEALTH Setting? YES____ NO____

If YES- Have you been discharged? YES____ NO____

Name of Home Health Agency_____ Phone Number_____

Responsible Party Statement / Collections Policy

As the Responsible Party, I agree that all charges that are not directly paid by my insurance company in accordance with the participation guidelines of my policy will be my responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance in the event my account becomes delinquent and is therefore in default of payment. I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old.

Responsible Party Signature — Date

Assignment of Benefits/ Authorization to Release Medical Information/ Consent to Treatment

I hereby assign all medical benefits to which I am entitled to Bodies In Motion Physical Therapy, in the event they file insurance on my behalf. I hereby authorize said assignee to release all information necessary to the appropriate authorities to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Bodies In Motion Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature — Date

Bodies In Motion Physical Therapy

HIPAA COMPLIANCE PRIVACY STATEMENT

Please know that information you give this office regarding yourself, or your case will remain confidential, and will not be discussed with others without your express permission. Letters regarding your progress will be sent to your referring physician, so that he/she can be kept up to date on your situation as it pertains to this case. Any sharing of information between Bodies in Motion Physical Therapy entities will be used as needed. Only necessary claims information, including diagnoses, will be sent to your insurance company on your behalf. Should you wish other arrangements, please consult the staff.

Every patient at Bodies In Motion has the right to inspect his/her physical therapy records.

We will make every effort to maintain your privacy and that of your records. If you have any questions or issues regarding this matter, please do not hesitate to bring them to the attention of the staff.

The staff has discussed this statement with me and has answered any questions about this policy.

Signature _____ Date _____

---

24 HOUR CANCELLATION/NO SHOW POLICY

Bodies in Motion Physical Therapy has a 24 hour cancellation/no show policy. Should you need to cancel an appointment, please contact our office at least 24 hours, or ONE BUSINESS DAY, in advance. Failure to notify our office of a cancellation 24 hours or one business day in advance, or a failure to arrive for your scheduled appointment will result in a **$40.00 Fee**. Insurance will not cover these fees.

I am aware of the Bodies in Motion Physical Therapy 24 Hour Cancellation/No Show policy.

Signature _____ Date _____

CONSENT TO E-MAIL FOR APPOINTMENT REMINDERS AND OTHER COMMUNICATIONS

Patients in our practice may be contacted via e-mail to remind them of appointments and/or provide general information related to Bodies in Motion Physical Therapy. By signing below, you consent to receiving communications at the e-mail address provided in the patient information section. We will not share your e-mail information with any other parties. Please indicate your preference:

_____ I consent to receive emails from Bodies in Motion Physical Therapy at the e-mail provided in the patient information section.

_____ I **DO NOT** consent to receive e-mails from Bodies in Motion Physical Therapy.

I understand that this request will apply to all future appointment reminders and communications, unless I request a change in writing.

Signature _____ Date _____