

BACK IN MOTION PHYSICAL THERAPY

"Customized Treatment for the Whole Body"

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Patient Information

Please Print Clearly:

Today's Date: _____

Patient Name: _____ SS#: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Best Phone Contacts: Primary: () _____ Secondary: () _____

Referring Source: _____ How did you hear about us? _____

Are you 18 and/or a dependent on a guardian's insurance? Yes / No

If yes, Guardian's Name: _____ Emergency Contact: _____

Insurance/Billing Information

Primary Insurance: _____ Insured Name: _____
Group# _____ Address: _____ City: _____
Insured Employer: _____ State: _____ Zip: _____ Ph: () _____
Relationship to Insured: _____ Insured DOB: _____ Insured: Male / Female

Secondary Insurance: _____ Insured Name: _____
Group# _____ Address: _____ City: _____
Insured Employer: _____ State: _____ Zip: _____ Ph: () _____
Relationship to Insured: _____ Insured DOB: _____ Insured: Male / Female

Have you had any physical therapy services this year? ___ If yes, how many sessions? _____

Treatment of Minors: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Legal Guardian Name: _____ Relationship: _____

Notice of Privacy: I acknowledge receipt of Notice of Privacy Practices. I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ Witness Signature: _____

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages for physical therapy based on your contract with them, not our office. It is your responsibility to know your insurance coverage and benefits as well as the deductible, co-insurance, and any other balances not paid by your insurance. We will assist you in receiving reimbursement; however, you are solely responsible for the remainder of any balances not paid by insurance.

You will be sent monthly statements, which will reflect any payments made by your insurance company on your behalf. Patient statements will be sent to the address given on page one. It is imperative that our office is notified of any address changes for either yourself or your insurance company so that proper follow up and collection efforts may be complete in a timely manner. Patients are responsible for any remaining balance on your account after 60 days from the date of service which has not been paid by your insurance company.

Specific time has been dedicated to your individualized care at Back In Motion Physical Therapy. Patients will be charged a \$40 cancellation fee due to a missed appointment without notification, or notification with less than 24 hour notice before the scheduled appointment time unless due to illness or emergency and for patients arriving more than 15 minutes past their scheduled appointment time.

I agree to be financially responsible for all charges. I have read and understand the above policies.

Patient Signature/Date

To Our Medicare Patients:

It is a requirement of Medicare that your physician/NNP review, date and sign a Plan of Care written by your physical therapist every 30 to 90 days to complete certification for your initial and continued therapy.

_____ initial

Assignment of Benefits:

I hereby authorize payment directly to Back In Motion Physical Therapy for physical therapy benefits otherwise payable to me for services rendered.

_____ initial

Authorization To Release Information:

I hereby authorize Back In Motion Physical Therapy to release any information required by my insurance company to process claims.

Patient Name (Print): _____ Date: _____

Patient Signature: _____