Patient Name: ____ Sex: M F
Last First M.I.

Social Security #: _____-_____-_____ DOB: ___ / ___ / ___
Marital Status: M S D W
Address:____
City: ______________________ State: __________ Zip: __________
Phone #: ________-________-________ Cell #: _______-________-________
Occupation: ____________________ Employer: ____________________
Employee Phone #: _______-_______-_______ E-mail: ____________________
Referring Doctor: ____________________ Primary Doctor: ____________________

Is your visit due to a Work Comp or an Auto Injury? Yes No
If yes, please provide billing information______________________________
____
____

Responsible Party Information

Name: ______________________________ Self Spouse Parent Other
Social Security #: _______-_______-_______ DOB: _____ / _____ / _____
Address:____
City: ______________________ State: __________ Zip: __________
Phone #: _________-_________-_________ E-mail: ____________________

Emergency Contact

Name: ____________________ Relationship to Patient: ____________________
Day Phone #: ________-________-________ Extension: ____________________

Information Consent Contact

I give my consent for Bodies in Balance to obtain and/or share information about myself or my child with the following person(s):

Name: ____________________ Relationship to Patient: ____________________
Day Phone #: ________-________-________ Extension: ____________________
Name: ____________________ Relationship to Patient: ____________________
Day Phone#:________-________-________Extension:____________________

Patient/ Guardian Signature:

____ Date: ___ / ___ / _____

CONSENT TO EVALUATION AND TREATMENT
I do hereby consent to the evaluation and treatment by Bodies In Balance Physical Therapy. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION
I authorize Bodies In Balance Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio, or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication and with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of medical information for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis. I am aware of the statutory privilege accorded by section 28 of the Public Law 1966, chapter 282 to confidential communications between a patient and a licensed psychologist/psychiatrist.

PRIVACY PRACTICES
I acknowledge receipt of the Bodies In Balance HIPPA Notice of Privacy Practice and the Patient Bills of Rights, which I have received at the time of this admission or previously.

ASSIGNMENT OF BENEFITS
I request that payment of the Medicare/Other Insurance benefits be made on my behalf to Bodies In Balance Physical Therapy for any services furnished to me by Bodies In Balance Physical Therapy. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL AGREEMENT
The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Bodies In Balance Physical Therapy. Bodies In Balance Physical Therapy will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/ patient is responsible for any co-payment, deductible, coinsurance, and all amounts identified by the insurer as the patient's responsibility.

Medicare Patients: I understand that if I do not have supplemental insurances, I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible.

ATTENDANCE
Your consistent attendance of the planned treatment regimen is paramount to your full recovery. Every effort is made to keep on schedule so we respectfully as patients to be prompt and to keep their appointments. If you need to change or cancel your appointment, we require a 24 hour notice. If you accumulate 3 cancellations and/or no-shows, your therapist may refer you back to your physician before scheduling, allow only same day appointments, or may choose to discharge you from therapy. **We reserve the right to charge for missed, changed, or cancelled appointments with less than a 24 hour notice.** The cancellation fee is the responsibility of the patient.

The undersigned certifies that s/he has read, understood, and accepts the terms of this form, is the patient, or is duly authorized by the patient as the patient's general agent to execute this form.
Signature of Patient or Responsible Party Date