THERAPIST: ________________________
DATE: _____________________________
TIME: _____________________________

PATIENT INFORMATION

Patient Name: _______________________________________ Date of Birth: ______________ SEX: _____

Address: ___________________________________ City: ____________________ State: ____ ZIP: _________________

Home Phone: ____________________________ Cell: _______________________ SS#: ___________________________

Referring Physician: _____________________________ Primary Physician: _____________________________________

Emergency Contact: _____________________________ Phone #: __________________ Relationship: _______________

Injury Result of Accident? Y or N Work Comp? ___________ Auto? _________ Date of Injury: __________________

Have you had Physical Therapy before? Y or N – Where? _____________ When? _____________ Ins? ___________

EMAIL Address: ________________________________ Student? Y or N Employer: __________________________

HEALTH INSURANCE INFORMATION

PRIMARY
Insurance Co. Name: ________________________________

Member ID #: ______________________________________

Subscriber (if different than patient) D.O.B.: _____________

Name: ____

Relationship: Spouse Parent Other ______________

Copay/Coinsurance: _________________________________

Benefit: ____

SECONDARY
Insurance Co. Name: _____________________________

Member ID #: ____________________________________

Subscriber (if other than patient) D.O.B.: ____________

Name: ____

Relationship: Spouse Parent Other __________

Copay/Coinsurance: _____________________________

Benefit: ____

WORKER'S COMPENSATION INFORMATION

Insurance Co. Name: _____________________________________ Claim #: ___________________________________
Address: ___________________________________ City __________________ State: _______ ZIP: _________________

Adjustor Name: ________________________ Phone: ___________________ Fax: _______________________________

Employer: _____________________________ Address: ____

Eval Authorized? _______________________ UR Fax: _____________________ UR Phone: _______________________

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name: ______________________________________ Claim #: _____________________________________

Address: _________________________________ City: _____________________ State: _______ ZIP: _______________

Adjustor Name: __________________________ Phone: ________________________________ Ext: ________________

Name of Insured (if other than patient): ______________________________ Relationship: ________________________

Open Claim/Pip Available?: ____

MOTION WORKS PHYSICAL THERAPY PATIENT AGREEMENT

The following are our office policies. ***Please read carefully*** *before signing and be sure to ask any questions you have prior to signing this document.*

As a condition of my treatment by Motion Works Physical Therapy (“MWPT”) I, ______________________________

(Please print name) agree to the following:

1. I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform MWPT of any changes to my insurance.

2. If MWPT does not receive insurance authorization for my treatment, I understand that I may sign an insurance waiver, which is valid for one treatment session.

3. I agree to pay any received copayment at every visit, or in advance.

4. I will pay for any non-covered medical supplies (ie. Theratubing, Ionto pads) at the time of disbursement.

5. We request a 24 hour notice in the event of cancellation. I understand that treatment might be terminated if I cancel or no-show for 3 appointments without rescheduling. *We only treat patients who help us get them well.*

6. If my check is returned to MWPT for insufficient funds, I agree to pay applied bank charges to the amount of the check.

7. **Consent to Treat/Informed Consent.** I authorize MWPT to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I authorize MWPT (including students in training) to administer treatment under the direction and supervision of the physical therapist. I will be given the opportunity to ask questions regarding my treatment, if they so arise, and that my physical therapist will be available to answer my questions. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks and my conditions may worsen on rare occasions. No guarantee or promise has been made to me concerning the results of treatment. I understand that I can terminate any treatment at any time if I so desire.

8. **Payment Guarantee.** In consideration of the services rendered and to be rendered by MWPT, I expressly guarantee payment of my account and agree to pay any charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance regardless of the disposition of the insurance carrier.

9. **Assignment of Benefits.** I authorize payment directly to Motion Works Physical Therapy for services rendered.

____ ____________________

Signature of Patient/Parent/Legal Guardian **Date**