MOVEMENT
PHYSICAL THERAPY

PATIENT REGISTRATION

NAME_____ TODAY'S DATE_____ /_____/_____

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

BIRTHDATE _____ /_____/_____ SOCIAL SECURITY # (Required for billing purposes) _____-____-_____

HOME PHONE (____)_____ WORK PHONE (____)_____ MOBILE PHONE (____)_____

EMAIL ADDRESS_____ DATE OF INJURY_____ /_____/_____

EMERGENCY CONTACT NAME_____ EMERGENCY CONTACT PHONE (____)_____

EMPLOYER_____ REFERRING DOCTOR_____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

Payment Agreement

I understand that payment for all therapy services and supplies is my responsibility regardless of the insurance or other third party coverage. We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to maximum allowance determined by each carrier. Not all services or supplies are a covered benefit in all contracts; examples include but are not limited to dry needling supplies, foam rollers, hyperboloids, and laser therapy. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We will process your insurance claims and request assignment of private benefits unless you pay in full at the time of treatment. You may also be asked to pay or automatically pay a deposit or estimate of payment at time of service. It is your responsibility to understand your insurance policy and coverage. Should insurance benefits paid to us result in a credit balance on your account, your money will be promptly refunded to you or your insurance company.

A monthly statement will be sent to you if you have a balance. We accept payment by cash, check, credit card or money order. Past due accounts, over 60 days, will be subject to a monthly rebilling charge and/or service fee. The credit card you provided here and/or on the *Credit Card Recurring Payment Authorization* form to secure your initial appointment will automatically be charged for your balance either at time of service or if non-payment of account extends beyond 90 days. Legal procedures for collection of past due accounts may also be initiated if non-payment of account extends beyond 90 days. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts.

For claims in pending litigation (or dispute as to the responsible party), prior written arrangements must be made for consistent payment of the account balance as we are unable to wait for resolution of a dispute. We reserve the right to discontinue treatments if reasonable, regular payments are not made or if the balance becomes untenable.

Medicare – we accept Medicare assignment and we will bill Medicare for you. Medicare pays 80% of the approved amounts and does not allow us to write off any portion of the 20% co-pay or deductible. Please understand that payment in full for all charges is your responsibility.

I authorize payment of medical benefits to Movement Physical Therapy, LLC, and I have read and understand this payment agreement. **Please initial:** _____

Consent to Treat and Authorization to Release Information

I voluntarily consent to *evaluation and treatment* by Movement Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the *release of information* acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer. I authorize *phone messages and email messages* regarding my treatment and appointments to be left with persons or machines at the phone numbers and email address I have provided. A copy of this facility's *Notice of Privacy Practices* has been provided to me. **Please initial:** _____

Video Surveillance Policy

I acknowledge that video surveillance is conducted on the premises of Movement Physical Therapy, LLC. I understand that this video surveillance is conducted in all treatment areas, business areas, and reception areas only at present. Movement Physical Therapy, LLC retains ownership of video surveillance records as permanent records and does not include transfer of this video recording when transferring medical records to any other medical provider, insurance company, or to parent/legal guardian. The video surveillances may be viewed and monitored at any time by authorized persons for the purpose of staff training, verification of compliance with employment polices of Movement Physical Therapy LLC, for purposes of legal proceedings, or to investigate misconduct. **Please initial:** _____

"No Show" Policy

Any patient who fails to arrive for a scheduled appointment without canceling the appointment more than 24 hours prior to the scheduled time is considered a "no-show." A no-show patient is charged a fee, as set by Movement Physical Therapy, LLC, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from care. **Please initial:** _____

By initialing above or signing below, I certify that I have read the *Payment Agreement*, *Consent to Treat and Authorization to Release Information, Video Surveillance Policy*, and *"No Show" Policy* sections above and agree to all statements contained therein.

_____

Patient/Parent or Guardian **Name (Please Print)**

_____

Patient/Parent or Guardian **Signature** Date