



Personal Information

Patient Name: _____ Sex: Male Female
Date of Birth: _____ Social Security # _____ Married Single Widowed
Address: _____ City _____ St.: _____ Zip: _____
Home Phone (____) _____ Cell Phone (____) _____
Email Address: _____ May we send you information via email Yes No
Are you Employed? Yes No Employment Status: Full time / Part Time / Retired
Employer Name _____ Phone# _____
Address _____ City _____ State _____ Zip _____
Are you a Full-Time Student? Yes No School Name _____
Emergency Contact Name: _____ Phone No. _____

Injury Information

When were you injured or first noticed your symptoms? _____
Please explain briefly how your injury occurred or what symptoms you are having: _____

Is this injury work related? Yes No Is this injury related to a car accident? Yes No
Have you had surgery? Yes No (If yes, please provide date of surgery: _____)

- Insurance Information

(Please complete all lines below & provide us with your insurance card)

Primary Insurance:

Plan Name: _____
Claims Address: _____
City: _____ State _____ Zip _____
Member ID# _____
Group Number: _____

Is the patient the subscriber? Yes No
Subscriber Name: _____
Address: _____
City: _____ State _____ Zip _____
Date of Birth: _____ SS# _____
Employer Name: _____
Relationship to Insured: _____

Secondary Insurance:

Plan Name: _____
Claims Address: _____
City: _____ State _____ Zip _____
Member ID# _____
Group Number: _____

Is the patient the subscriber? Yes No
Subscriber Name: _____
Address: _____
City: _____ State _____ Zip _____
Date of Birth: _____ SS# _____
Employer Name: _____
Relationship to Insured: _____

Consent for purposes of Treatment, Payment & Healthcare Operations

motion hand & physical therapy

Patient Name: _____

-Consent-

I (or my legal guardian or parent if under 18) authorize Centers for Hand & Physical Rehabilitation, Inc. (DBA **motion** hand & physical therapy) to provide medical care reasonable by today's standards.

Patients Signature: _____ Date _____

Parent/ Guardian Signature: _____ Date _____

Witness Signature: _____ Date _____

-Financial Responsibility-

Payment is due at the time of service unless other arrangements have been made. Insurance contracts are made between the patient and insurance company, NOT the therapist and the insurance co. You are at all times directly responsible for the payment of this bill. We are, however prepared to file forms for you to help you recover the portion of your medical expenses that is covered by your insurance.

The person who signs this agreement accepts full responsibility for payment of charges incurred for all deductibles, co-payments, products, and services not covered by my insurance company or third party payor unless such liability is expressly waived by state or federal law. If this account goes into default and is referred to an attorney or agency for collection, you may be responsible for reasonable attorney fees and costs of collection of any past due patient balances for deductibles, co-payments and uncovered charges.

Assignment of benefits to provider of service: I assign payment of medical benefits directly to the provider.

Verification of Benefits: As a courtesy we may call and verify that you have current coverage. We do not guarantee coverage or rate of payment by your insurance company. We will advise you of any information we receive from your insurance carrier during that call, but we do not guarantee the accuracy of the information provided to us. We suggest that you contact your insurance carrier within 24 hours of treatment to assure you have adequate benefits to cover occupational or physical therapy.

Release of medical information: I authorize the release of all medical information necessary to process this claim including: medical history, diagnosis, prescriptions and other medical information and all medical expenses related to my treatment. This authorization shall be valid for the duration of this claim. I agree that a reproduced copy of this authorization will be valid as well as the original

Cancellation Policy: If you are going to be late for an appointment, please call us. If you arrive more than 15 minutes late, the therapist may not be able to accommodate you and your appointment will be treated as a cancellation. If you do not call 24 hours prior to your appointment to cancel, it will be necessary to charge you. The cancellation fee is \$25.00 and is **not** covered by insurance carriers, workman's compensation, or Medicare.

Patients Signature: _____ Date _____

Parent/ Guardian Signature: _____ Date _____

Witness Signature: _____ Date _____

If you refuse to sign this agreement it does not relieve you of any liability. Your acceptance of services constitutes acceptance of billing and cancellation policies.

-Notice of Privacy Practices-

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patients Signature: _____ Date _____

Parent/ Guardian Signature: _____ Date _____

Witness Signature: _____ Date _____