bodywise
PHYSICAL THERAPY

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ PREFERRED PRONOUN: _____

MAILING/STREET ADDRESS: _____

CITY:_____ ST:_____ ZIP:_____ PHONE #'S: HOME: _____

WORK: _____ CELL: _____ EMPLOYER NAME: _____

HOW DID YOU HEAR ABOUT US?_____

REFERRING PHYSICIAN: _____ EMAIL ADDRESS:_____

EMERGENCY CONTACT/RELATIONSHIP & PHONE: _____

RESPONSIBLE PARTY INFORMATION *(IF PATIENT IS UNDER 18 YEARS OLD)*

NAME: _____ DATE OF BIRTH: _____ PREFERRED PRONOUN:_____

MAILING/ STREET ADDRESS (if different from above): _____

CITY:_____ ST:_____ ZIP:_____ PHONE #'S: HOME: _____

WORK: _____ CELL: _____ EMPLOYER NAME: _____

EMPLOYER NUMBER:_____

PRIMARY HEALTH INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:_____ SUBSCRIBER NAME:_____

SUBSCRIBER ID #:_____ POLICY/GROUP #:_____

SECONDARY HEALTH INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:_____ SUBSCRIBER NAME: _____

SUBSCRIBER ID #:_____ POLICY/GROUP #:_____

MVA/WORKERMAN'S COMPENSATION INSURANCE INFORMATION

INSURANCE NAME: _____

ADJUSTER NAME:_____ PHONE: _____

DATE OF INJURY:_____ CLAIM #:_____

I verify that the above information is accurate. I authorize assignment of insurance benefits, and for Bodywise Physical Therapy to furnish all information necessary to process my claims.

_____ _____

Patient/Guarantor Signature Date

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Financial Agreement/Assignment of Benefits

As a courtesy, Bodywise Physical Therapy will contact your insurance company for a quote of your available benefits, and file your claims directly, however we cannot guarantee any coverage that may or may not be available to you.

Please note that some insurance plans may apply massage, chiropractic, acupuncture, naturopathic, or other services to your physical therapy benefit limits.

Please initial the following:

_____ I agree it is ultimately my responsibility to understand my insurance benefits for physical therapy.
_____ I understand my deductible, coinsurance, or copay will be collected at the time of service.
_____ I understand I am responsible for any remaining balance due after my insurance processes my claim.
_____ I understand that any payment for balances due not received within 30 days of receipt of billing will be charged 5% interest ($5.00 minimum).
_____ I understand that all unprocessed or unpaid insurance claims will be transferred to my responsibility after 90 days.
_____ I understand there is a $50.00 fee applied for returned checks.
_____ I understand that in the event my account should be referred to an outside professional collection agency, or attorney, I am responsible for any and all collection/attorney fees, as well as expenses associated with the collection of my account.
_____ I request/agree to receive messages via text or email from Bodywise Physical Therapy.

Cancellation Policy

Bodywise Physical Therapy has a 24-hour cancellation policy. All cancellations must be made by phone. Cancellations are not accepted via email or text. Arriving more than 15 minutes late to an appointment will be considered a late cancellation, and result in a fee. Failure to arrive at an appointment will result in a fee. Late cancellation/No-show fees are $100.00 the first time, $150.00 the second time, and $200.00 for any subsequent incidents. Multiple violations may result in discharge. Payment for any missed appointment is due in full upon my next visit.

_____ I understand and agree to the above cancellation policy.

Consent for Treatment and Release of Medical Records

_____ I give my consent for care and treatment at Bodywise Physical Therapy.
_____ I authorize Bodywise Physical Therapy to request medical records pertaining to my condition(s) from my primary care provider, as well as other providers directly involved in my case.

Privacy Policy **(Choose one)**

_____ I have reviewed the privacy policy available on the Bodywise website.
_____ I decline to view the privacy policy available on the Bodywise website.

_____	_____	_____
Printed Patient/Guarantor name	Signature Patient/Guarantor	Date

Bodywise Physical Therapy will retain a copy of this document in the EMR which shall be considered effective, and valid as the original. You have the right to request a copy of this document at any time.