Body One Physical Therapy Adult Patient Information

Patient Information

First Name_____ MI_____ Last Name_____ DOB_____SS#_____

Address_____ City_____ State _____ Zip_____ Gender_____

Employer_____ Occupation_____

Work Place Phone Number _____ Work Place Zip _____

Emergency Contact Information

First Name_____ Last Name_____

Daytime Phone_____ Relationship_____

Missed Appointment Policy

All appointments require a 24-hour cancellation notice to avoid a missed appointment fee.

Please help us to better serve you and others by keeping scheduled appointments. We reserve the right to bill a **$40.00** missed appointment fee for appointments cancelled without at least 24 hours advanced notice. Consideration will be given for emergency situations.

It is our practice to confirm appointments on the business day prior to the scheduled appointment. Please advise our office staff of any changes to your contact information or your contact preferences.

I affirm the information above is correct and I understand the missed appointment policy.

_____

Signature of Patient or Responsible Party **Date**

Originated: February 2004 *Revised: July 2017*

North Meridian – 8902 N Meridian St, Ste 120 – 317-581-1890
Downtown – 251 N. Illinois, Ste 190 – 317-634-0600
Fishers – 10412 Allisonville Rd, Ste 117 – 317-567-8500
South Emerson – 7855 S Emerson Ave, Ste W – 317-889-5340
Zionsville – 70 Brendon Way – 317-733-2800

Body One Physical Therapy Financial Policy

Body One Physical Therapy is committed to providing you with the best possible physical therapy care. The timely payment of your bill is an essential part of your treatment. The patient will be responsible for all copay, deductible and coinsurance amounts due at the time services are rendered. Our office accepts cash, checks and Visa/MasterCard/Discover/American Express credit and debit cards.

I understand that this office will make every attempt to obtain payment from my insurance carrier including Medicare and/or other third party payer. **I acknowledge and understand that payment for services may be denied by my insurance carrier, including, but not limited to, pre-existing conditions, routine, experimental, not reasonable or necessary, or work related reasons.**

IF MY INSURANCE PAYS ME DIRECTLY, I agree to forward the payment to this office within 10 days of my receipt of payment. I further understand that failure to comply with this policy could result in Body One Physical Therapy taking appropriate legal action to collect this amount.

I acknowledge that I am financially responsible for all fees incurred for services rendered regardless of insurance. Any balance on my account that remains unpaid for more than 60 days may be assessed a rebilling fee of $25.00. If a balance remains unpaid for more than 90 days, the account may incur an additional $50.00 rebilling fee. Once a balance goes unpaid past 100 days, the account may be turned over to a Third Party Billing Service. **You agree that you will pay any interest that can be added at the current legal rate as well as all collection fees, returned check fees, attorney fees and court costs incurred for the collection of all sums due.**

Additional Fees:

- A fee of $25.00 will be charged for any returned check.
- Any supply or durable medical equipment provided to you will exclusively be your financial responsibility and will need to be paid for at the time of purchase.

Assignment of Benefits

I authorize and direct my insurance carrier to pay benefits to Body One Physical Therapy, LLC for services rendered to me, regardless of the carrier's policy concerning this office. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

My signature affixed here may be kept on file to suffice for any signatures required on insurance claim forms. In addition, I authorize Body One Physical, LLC to release pertinent information to my insurance carrier(s) and the Indiana Department of Insurance concerning my condition and treatments rendered.

I have read this financial policy. I understand and agree to comply with this financial policy. I authorize the release of any medical information required throughout the course of examination and treatment and permit payment directly to Body One Physical Therapy for any monies due for the services rendered.

_____

Signature of Patient or Responsible Party Date

_____

Signature of Body One Physical Therapy Representative Date

Body One Physical Therapy HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Compliance Officer at Body One Physical Therapy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations, and outcomes research. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Authorization to Release Information

I authorize Body One Physical Therapy to disclose my information to the following:

Name:_____ Relationship:_____

□ Make/Cancel Appointments Initials:_____ □ Discuss Condition and Care Initials:_____ □ Receive Medical Records Initials:_____

Name:_____ Relationship:_____

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Name:_____ Relationship:_____

□ Make/Cancel Appointments Initials:_____ □ Discuss Condition and Care Initials:_____ □ Receive Medical Records Initials:_____

□ I do not authorize any person to have access to my information. Initials:_____

_____

Signature of Patient or Responsible Party Date

_____

Signature of Body One Physical Therapy Representative Date

Body One Physical Therapy Medical History

To help your therapist complete a thorough examination, please fill out the following form concerning your medical history. Fill out all areas thoroughly. If any area is not applicable, mark N/A. Please print. Thank you.

Name: _____

Allergies:
List any allergies (bee stings, latex, medications, etc.) you have:

_____

_____

Please check if you have EVER been diagnosed with any of the following conditions:

- ☐ Cancer
- ☐ Other arthritic conditions
- ☐ Depression
- ☐ Tuberculosis
- ☐ Kidney disease
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Asthma
- ☐ Chemical dependency
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Hepatitis
- ☐ Stroke
- ☐ Anemia
- ☐ Heart problems
- ☐ Circulation problems
- ☐ Emphysema/Bronchitis
- ☐ Thyroid problems
- ☐ Multiple sclerosis
- ☐ Other: please describe_____

WOMEN: Are you currently pregnant? _____

Please list any surgeries or other conditions for which you have been hospitalized:

Date	Reason for Surgery/Hospitalization	Date	Reason for Surgery/Hospitalization
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____

Please check any of the following which you have recently noticed:
☐ Weight loss/gain ☐ Nausea/vomiting ☐ Fatigue ☐ Weakness ☐ Fever/chills/sweats ☐ Numbness/tingling

Medical Power of Attorney-if applicable

☐ I have a signed Medical Power of Attorney. ☐ I have a copy of my signed Medical Power of Attorney.

Name of Designee:_____ Relationship:_____

Daytime Phone: _____

_____ _____
Patient Signature **Date**

_____ _____
Therapist Signature **Date**

Body One
Physical Therapy Sports Rehabilitation

Medication List (Or Attach Preprinted Medication List)

Please list all current Medicine including Over the Counter Meds	Dose	Frequency	Route Medicine is Received ie: By Mouth, Injection, Spray, etc…

Please check this box if currently on no medications ☐

Patient Signature Date