Body One Physical Therapy Minor Patient Information

Patient Information

First Name_____ MI_____ Last Name_____ DOB_____

Address_____ City_____ State _____ Zip_____ Gender_____

Parent/Guardian Information ☐ Custodial Parent/Guardian ☐ Subscriber for Insurance ☐ Receives Account Statements

First Name_____ MI_____ Last Name_____ DOB_____SS#_____

Address_____ City_____ State _____ Zip_____

Daytime Phone_____ Relationship_____

Employer_____ Phone:_____

Parent/Guardian Information ☐ Subscriber for Insurance ☐ Receives Account Statements

First Name_____ MI_____ Last Name_____ DOB_____SS#_____

Address_____ City_____ State _____ Zip_____

Daytime Phone_____ Relationship_____

Employer_____ Phone:_____

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: January 2020*

Body One Physical Therapy Minor Patient Treatment Consent Form

"I, _____, hereby give my permission as parent/guardian for the minor child, _____, to receive treatment from Body One Physical Therapy."

"In consideration of my minor child's participation in Physical Therapy services with Body One Physical Therapy, I, _____, hereby release Body One Physical Therapy (its employees and owners), from any claims, demands, and causes of action arising from my minor child's participation in the Physical Therapy program. "

"I, _____, hereby release Body One Physical Therapy from liability now or in the future during the treatment of my minor child, _____. "

"I understand that, in my absence, my minor child will make decisions regarding Physical Therapy services and I will be responsible for all charges associated with those services."

"I hereby affirm that I have read and fully understand the above."

Signature of Parent/Guardian: _____Date:_____

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. You will be presented with an estimate of the patient due portion for your visit today. Patient due amounts, such as co-pays and deductible amounts are due at the time of service. We are happy to bill your insurance company as we ask that you pay the patient due amount as soon as you hear from your insurance company.

When paying from statement, any patient balance is due within 14 days of receipt. If we do not hear from you, and you have not contacted the billing office to make alternative payment arrangements, we will begin collection proceedings. We understand there are sometimes extenuated circumstances, and we want to work with you. If you need to make arrangements for payment, please talk with our front office staff or a member of the billing team.

You agree that you will pay all charges, collection fees, returned check fees, attorney fees and court costs incurred by 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.

_____

Date Signature of Patient or Responsible Party

_____

Print Name of Patient or Responsible Party

_____

Date Signature of Body One Physical Therapy Representative

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:_____

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

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**

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