

# Body One Physical Therapy Minor New Patient Checklist

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## Did you:

- Complete the Body One Physical Therapy **Minor Patient Information Form** and read, sign and date the **Missed Appointment Policy** section of the form?
- Read, sign and date the **Minor Patient Treatment Consent Form**?
- Read, sign and date the **HIPPA Consent Form**?
- Read, sign and date the **Financial Policy Form**?
- Complete, sign and date the **Medical History Form**?
- Complete, sign and date the **Medication List**?

## Your First Appointment

- Please bring all of your completed paperwork (see checklist above) and arrive 10 minutes prior to your scheduled appointment time. If your paperwork is not complete, please arrive 20 minutes prior to scheduled appointment time.
- A parent or guardian must accompany the patient for their first appointment.
- If your physician ordered physical therapy, please bring a copy of the order or prescription, if it has not already been sent to our office.
- Please bring your insurance card(s).
- Please bring photo identification (Driver's License, etc...).
- Be prepared to pay for your required patient financial obligation (copay, deductible, or coinsurance).
- Dress appropriately and comfortably (t-shirt or sports bra for upper body and sweatpants or shorts for lower body) for assessment, treatment and exercise.



# Body One Physical Therapy Minor Patient Information

## Patient Information

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Gender \_\_\_\_\_

Email Address \_\_\_\_\_ Appointment Notification by:  Phone  Email  Text  
 Patient  Parent/Guardian

## 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 \_\_\_\_\_ Work 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 \_\_\_\_\_ Work Phone: \_\_\_\_\_

How did you hear about our practice? (Please Check)  Repeat Patient  Physician  Family/Friend  Website  Google  
 Facebook/Social Media  Billboard  Event  Insurance  Employee

## 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: August 2020*

North Meridian – 8902 N Meridian St, Ste 120 – 317-581-1890  
Fishers – 10412 Allisonville Rd, Ste 117 – 317-567-8500

Zionsville – 70 Brendon Way – 317-733-2800



## Body One Physical Therapy Minor Patient Treatment Consent Form

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“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

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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: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Make/Cancel Appointments | <input type="checkbox"/> Discuss Condition and Care | <input type="checkbox"/> Receive Medical Records |
| Initials: _____                                   | Initials: _____                                     | Initials: _____                                  |

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Make/Cancel Appointments | <input type="checkbox"/> Discuss Condition and Care | <input type="checkbox"/> Receive Medical Records |
| Initials: _____                                   | Initials: _____                                     | Initials: _____                                  |

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Make/Cancel Appointments | <input type="checkbox"/> Discuss Condition and Care | <input type="checkbox"/> Receive Medical Records |
| Initials: _____                                   | Initials: _____                                     | 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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Rheumatoid arthritis         |
| <input type="checkbox"/> Other arthritic conditions | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Hepatitis                    |
| <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Kidney disease             | <input type="checkbox"/> Anemia                       |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Heart problems               |
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Circulation problems         |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Emphysema/Bronchitis         |
| <input type="checkbox"/> Chemical dependency        | <input type="checkbox"/> Thyroid problems             |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Multiple sclerosis           |
| <input type="checkbox"/> Cholesterol                | <input type="checkbox"/> 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

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Patient Signature

Date