

**BODY MECHANICS PHYSICAL THERAPY
NEW PATIENT REGISTRATION**

ASSIGNED TO: _____

APPOINTMENT DATE: _____

PLEASE PRINT CLEARLY AND FILL IN ALL INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Email Address _____

Date of Birth _____ Sex M / F Social Security Number _____

Marital Status: Single () Married () Divorced () Legally Separated () Widowed ()

Student Status: Full Time () Part Time () Non Student () Employment Status: Not Employed () Full Time () Part Time () Retired ()

Employer / School Name _____

Employer / School Address _____ Employer Phone _____

Emergency Contact Name _____ Relationship _____ Phone _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

Doctor _____ Family Member _____ Friend _____ Website _____ Advertisement _____
Complimentary Coupon _____ Insurance Co. _____

REFERRING PHYSICIAN INFORMATION

Referring Physician Name _____ Physician Phone _____

REASON FOR TREATMENT (briefly describe) _____

Illness? _____ (date of first symptom) _____ OR Injury? _____ (date of injury) _____

Work Related? Yes () No () Accident related? Yes () No () How?: Car () Home () Other Accident ()

Name and Phone Number of Adjuster or Case Manager _____

INSURANCE INFORMATION

Primary Insurance Co _____ Policy Holder _____

Policy Holder Date of Birth _____ Policy Holder Social Security # _____ Relationship _____

Secondary Insurance Co _____ Policy Holder _____

Policy Holder Date of Birth _____ Policy Holder Social Security # _____ Relationship _____

RESPONSIBLE PARTY STATEMENT

As the Responsible Party, I agree that all charges that are not directly paid by my insurance company will be MY RESPONSIBILITY.

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Body Mechanics Physical Therapy in the event they file insurance on my behalf. A copy of this assignment shall be considered as effective and valid as the original.

I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default in payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt, including but not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for the unpaid balances over 90 days old.

I hereby authorize said assignee to release all information necessary to secure payment of said benefits. I understand I may need to complete and return additional forms from/to Independent Diagnostic Services according to governing laws and policies of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I do hereby consent to such treatment by the authorized personnel of Gainesville Physical Therapy as would be dictated by prudent medical practice/treatment of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature _____ **Date** _____

By Signing below I acknowledge receipt of the Body Mechanics Physical Therapy Privacy Notice which follows standard HIPPA (Health Information and Privacy Act) regulations.	
Patient Name:	
Signature:	Date:

BODY MECHANICS

PHYSICAL THERAPY 

PUTTING YOU BACK IN MOTION

Cancellation Policy

We require 24 hours notice in the event of a cancellation.

Please have an alternate time in mind to reschedule your appointment to ensure that you maintain the fully recommended number of treatments each week. Maintaining treatment as your doctor and therapist have recommended will ensure optimum rehabilitation. **There is a \$50 fee for cancellations and no-shows that do not follow these guidelines.**

Patient Signature: _____

Date: _____

Supply Policy

A **\$20.52 supply fee** will be collected at your initial physical therapy visit. This fee includes **customary supplies** that will be used during your treatment. Any additional supplies that your therapist recommends to supplement your treatment should be paid for at the time of purchase. Please let your therapist know if you have any additional questions regarding physical therapy supplies.

Thank You!