iMotion Physical Therapy, Inc.

Patient Registration Form

Completed by: _____ Date: _____

PATIENT INFORMATION

Last Name_____ **First Name**_____ **Middle Name**_____ ☐ **Male**

Street_____**Apt. No.**_____ **P.O. Box**_____ ☐ **Female**

City_____ **State**_____ **Zip**_____ **Home Phone**_____ **Work Phone**_____ **Cell Phone**_____

Social Sec # _____**Date Of Birth**_____ **Referred By**_____

Email Address _____

RESPONSIBLE PARTY INFORMATION (IF PATIENT UNDER 18)

Last Name_____ **First Name**_____ **Middle Name**_____ ☐ **Male**

Street_____**Apt. No.**_____ **P.O. Box**_____ ☐ **Female**

City_____ **State**_____ **Zip**_____ **Home Phone**_____ **Work Phone**_____ **Cell Phone**_____

Social Sec # _____**Date Of Birth**_____**Email Address** _____

PRIMARY CARE PHYSICIAN

Primary Care Physician_____ **Tel #:** _____

Address_____**City**_____**State**_____**Zip**_____

REFERRING PHYSICIAN

Primary Care Physician_____ **Tel #:** _____

Address_____**City**_____**State**_____**Zip**_____

Please notify the therapist of any and all medications you are currently taking.

OFFICE USE ONLY

PRIMARY INSURANCE COMPANY INFORMATION

Company Name_____ **Group Name/Number** _____ **Effective Policy Date**_____/_____/_____

ID # _____ **Co-Pay Amount** _____ **Max Physical Therapy Visits Per Year** _____

Subscriber Last Name_____ **First Name**_____ **Middle Name**_____

Deductible _____ **Co Insurance** _____ **Deductible Met This Year** _____ **Effective Date** _____

Insured party must sign for all claims. Dependent patient must sign if not a minor. I certify that the information that I furnish is true and correct. I know it is a crime to fill out this form with facts that I know to be false or to leave out facts I know are important.

Initials of Patient or Legal Guardian _____ **Date:**_____

iMotion Physical Therapy, Inc.

Financial Responsibility Policy

We welcome you as a patient and appreciate the opportunity to provide you with quality physical therapy. We would like to inform you of our billing policy. We will submit bills to most insurance companies on your behalf. Some insurance companies pay fixed rates for physical therapy procedures and others pay a percentage of the charge. This information is verified for each patient by a member of our staff as a courtesy and is based on the assumption that you are entitled to physical therapy benefits. **This verification is not a guarantee of benefit or payment. You should also follow up with your insurance company to find out your physical therapy eligibility and benefit. It is your responsibility to understand your insurance policy.**

Please note that you may not be entitled to physical therapy benefits if:

- you have undergone previous physical therapy for a similar injury
- this injury is related to a motor vehicle accident
- you belong to a healthcare group with no out-of-network benefit
- you have not obtained the proper managed care authorization

Please initial after reading the following

_____ (initial) I understand that all co-insurance payments and deductibles required by my insurance policy are the contractual obligation between myself and my insurance company, and are expected at the time of the visit. I fully understand that I am 100% responsible for the full amount due until my deductible is met. I fully understand that I am 100% responsible for the full contractual amount if Insurance is invovled.

_____ (initial) I understand that it is patient's responsibility to obtain the referral prior to the visit. **If you do not have a referral at the time of the visit, you may be responsible for the payment in full.**

For Medicare: _____ (initial) I am currently not receiving home health care. I understand that medicare does not pay for home health services and outpatient physical therapy services same time. I also understand that I will be responsible for outpatient physical therapy services if I fail to inform about my home health services to iMotion Physical Therapy, Inc.

***FOR WORKERS COMP* PATIENTS ONLY:**

_____(initial) I, patient understand that iMotion Physical Therapy has a strict no show & late cancellation policy. Under Workers Compensation Laws, Providers are legally unable to charge me for no shows or late cancellations. Due to this factor, I will be given one chance. If I violate this policy, representatives of iMotion Physical Therapy reserve the right to discharge me from their care. iMotion Physical Therapy takes the care and services they provide as well as their policies very seriously as they hope their patients do.

If you have any questions, please contact any member of our administration team.

iMotion Physical Therapy, Inc.

CANCELLATION AND NO SHOW POLICY

The following are our policies regarding cancellations and no-shows. We take this subject seriously at iMotion Physical Therapy Inc also DBA Omega Sports Rehabilitation at Los Gatos and San Jose locations *because it can make the difference between whether you succeed in your treatment or not.* Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow you therapist's instructions and we will be able to help you achieve your goals in treatment.

- **We require 24 hours notice in the event of a cancellation**. It is your responsibility when you call in to have an alternative time in mind that will ensure you get in the full number of treatments that week whenever possible.
- **There is a $25 charge for cancellation without proper notice.** This charge will not be covered by insurance but will have to be paid by you personally.
- **There is a No Show fee of $75.** A No Show fee is applied when an appointment is missed appointment without 24 hour notification. This charge will also not be covered by insurance but will be paid by you personally.
- For Workers Compensation and Personal Injury Patients: Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally relieved. Either of these conditions can seem to be a reason not to come in:
    - You're feeling worse and think that the treatment is not working.
    - You're feeling better and no longer feel the need to be treated.

  Neither of these conditions is legitimate as a reason not to come in for treatment.

    - If you are in pain, take steps towards alleviating it by showing up for your prescribed treatments.
    - If you're out of pain, now is the time that we can begin doing some real corrections of the underlying *causes* of your problem, educating you so that you won't re-injure yourself, etc.

Why are we so serious about this?

When you do not show up as scheduled, three people are hurt. You, because you don't get the treatment you need as prescribed by the doctor and/or Physical Therapist, the therapist who now has a space in his/her schedule since the time was reserved for you personally, and another patient who could have been scheduled for treatment if proper advance notice of a cancellation had been given.

Please co-operate with us in this regard. We are looking forward to working with you.

_____ _____

Patient Signature Date

iMotion Physical Therapy, Inc.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment and generally carry all the Practice's health care operations. I also authorize the Practice to disclose my medical information to insurers and provider outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. By my signature below, I acknowledge that I have read a copy of the Practice's Notice of Privacy Practices

_____

Patient Signature

Patient Name Date

CONSENT FOR TREATMENT

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **iMotion Physical Therapy, Inc.** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. I also understand that because of the nature of physical therapy I may be sore up to 72 hours.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **iMotion Physical Therapy, Inc.** to treat the minor patient named in the attached forms while I am not present.

PATIENT NAME: _____

PATIENT/ GUARDIAN SIGNATURE: _____

DATE: _____

iMotion Physical Therapy, Inc.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION NAME	DOSE	FREQUENCY