

In Motion Physical Therapy

Patient Information:

Last Name	First Name	MI	Date of Birth	Social Security Number
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Home Address	City	State	Zip
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Home Phone	Cell Phone	Marital Status
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Email (internal use only)

Employer Name & Occupation	Business Phone	May we leave a message at this number?
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Referring Physician Information:

Doctor's Name	Phone	Diagnosis/Area to be treated
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Emergency Contact/Legal Guardian Information:

Last Name	First Name	Phone Number
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How did you hear about In Motion Physical Therapy?

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Cancellation / No Show Policy

Although you will not be responsible for any fees for canceling an appointment, IN MOTION PHYSICAL THERAPY appreciates 24-hour notice so that other patients may have the opportunity to schedule in the time vacated by your cancellation.

If you cancel **three consecutive times** or **no-show for three appointments**, please be advised that your therapist will discharge you from care and send the referring physician a progress note regarding your non-adherence to your therapy plan of care.

Private Practice

I have read & understand the notice of privacy practices of IN MOTION PHYSICAL THERAPY.

Assignment of Benefits/Authorization to Release Medical Information/ Consent to Treatment

I hereby assign all medical benefits to which I am entitled to In Motion Physical Therapy, LLC in the event they file insurance on my behalf. 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 of payment. I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is 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 charges at a rate of 1.5 % per month (18% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of In Motion Physical Therapy, LLC as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

X _____
Authorized Signature

X _____
Date