Body In Balance Physical Therapy
Patient Demographics

Name: _____DOB:_____Age:____Gender: M / F
Mailing Address: _____City: _____State:___Zip:_____
Home Number: _____ Work/Cell Number: _____
May we leave a message? Yes / No Social Security #(optional): _____
Newsletter sign up email: _____
How did you hear about us? ☐ Online ☐ Phone Book ☐ Doctor ☐ Family/Friend: _____

Referring Provider: _____ Date last seen: _____
Primary complaint: _____Next Appointment: _____

Emergency contact: _____Phone: _____

Primary Insurance Co.: _____
Policy Holder's Name: _____ DOB: _____ Gender: M / F
ID #: _____ Grp #: _____ Relationship: _____

Secondary Insurance Co.: _____
Policy Holder's Name: _____ DOB: _____ Gender: M / F
ID #: _____ Grp #: _____ Relationship: _____

Tertiary Insurance Co.: _____
Policy Holder's Name: _____ DOB: _____ Gender: M / F
ID #: _____ Grp #: _____ Relationship: _____

Injury Accident ONLY:
Date of Injury: _____ Insurance Company: _____
Adjuster: _____Phone #: _____ Claim #:_____
Related to: (circle) Auto Home Sports Work-Employer Name:_____

I have authorized Body In Balance Physical Therapy to discuss my medical/billing information with:
Name:_____ Phone: _____ Relationship: _____
Name:_____ Phone: _____ Relationship: _____

Please read and initial all of the following.
____ I hereby authorize treatment by Body In Balance Physical Therapy.
____ I authorize payment of benefits and release of medical information necessary to process insurance claims.
____ I understand that I am financially responsible for all services rendered regardless of litigation or insurance reimbursement.
____ I understand that all charges incurred after 120 days from date of service become patient responsibility, regardless of insurance status.
____ I understand that some Insurance Companies require preauthorization or have a limit on Physical Therapy payment for treatment.
____ I understand that co-pays and co-insurances are due at time of service.
____ I understand that there is a $25.00 non-billable charge for missed appointments without a 24 hour notice.
____ I understand that some supplies are not covered by Insurance.

Patient Signature: _____Date: _____

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW FORM CAREFULLY.

OUR LEGAL DUTY

Body In Balance Physical Therapy is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Body In Balance Physical Therapy uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you. Body In Balance Physical Therapy will always obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any other reason, you may later revoke that authorization to cease future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Body In Balance Physical Therapy will consider all such request on a case-by-case basis. The company is not legally required to accept requests.

_____ I acknowledge that I have received a copy of the Notice of Patient Information Practices as stated above.

_____ I acknowledge that I have declined a copy of the Notice of Patient Information Practices as stated above.

_____ _____

Patient Name Date

BODY IN BALANCE PHYSICAL THERAPY

CANCELLATION AND NO SHOW

POLICY

This policy has been established in order to provide the highest level of Physical Therapy Service to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

• Patients must call at least 24-hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of appointment will be considered a late cancellation.

• A patient will be allowed to continue with their therapy after one no-show/late cancellation, provided an explanation is supplied to the Therapist.

• **After two (2) no shows/late cancellations within a 30 day period, the patient will be able to schedule day of appointments only.**

• We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by the Physical Therapist.

• Patients will always be provided copies of their scheduled appointments.

Our practice firmly believes that good physical therapist/patient relationship is based upon understanding and good communication. Questions about cancellation and no show policy should be directed to the Office Manager at (907) 746-0722.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ _____

Patient Signature Date