JOINT MOVEMENTS
PHYSICAL THERAPY

Name:				**D.O.B:**	**Sex:**	**Male**	**Female**
Address:				**City:**	**State:**	**Zip:**	
Insured's Name				**Insured's D.O.B.:**			
Home Phone #:		**Cellular Phone #:**		**Social Security #:**			
Patient's Status:	**Single**	**Married**	**Other**	**Employed (FT or PT)**	**Student (FT or PT)**		
Is the patient's condition the result of:		**Employment Accident**		**Automobile Accident**	**Other Type of Accident**		
Primary Insurance:				**Secondary Insurance**			
Email Address:				**Secondary Insured Name & D.O.B.**			

Consent: I do hereby consent to the evaluation and treatment by Joint Movements Physical Therapy. I understand that it is my right to accept or refuse treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Assignment of Benefits: I request that payment of the Medicare/Other Insurance benefits be made on my behalf to Joint Movements Physical Therapy for any services furnished to me by Joint Movements Physical Therapy. I authorize any holder of medical information about to release to the Health Care Financing Administration and it's agents any information to determine these benefits or the benefits payable for related services

Financial Agreement: The undersigned agrees, whether signing as an agent or patient, that he/she individually obligates him/herself to pay for services rendered in accordance with the regular rates and terms of Joint Movements Physical Therapy. Joint Movements Physical Therapy will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, co-insurance, and all amounts identified by the insurer as the patient's responsibility. The undersigned also understands and agrees to submit any insurance checks which may be received for services rendered at this facility to Joint Movements Physical Therapy. For all plans that have co-insurances, a credit card will need to be kept on file as the duration of treatment may end before receipt of explanation of benefits from the insurance carrier.

Change Notification: The undersigned understands that he/she must notify Joint Movements Physical Therapy of any changes with regards to:

1. Changes to referring physician
2. Changes to insurance coverage of any kind (ie: Primary, Secondary, etc)
3. Changes with regard to any benefits being used concurrently outside of Joint Movements Physical Therapy

Failure to notify Joint Movements Physical Therapy of any changes mentioned above, or that may impact your care at this facility may result in a claim denial from the insurance company, at which case the patient/the undersigned will be responsible for payment for the uncollected amount from the insurance company

Patients with Medicare as their Primary Insurance: The undersigned understands that if said patient does not have a secondary/supplemental insurance, said party will be responsible for the 20% co-insurance portion that is not covered by Medicare Part B for services rendered.

Cancellation Policy: The undersigned understands and agrees to an out of pocket fee of **forty ($40) for any scheduled appointment that is missed without notice or cancelled without 6 hour notice**. The cancellation fee will be required to be paid prior to the next treatment

Signature:_____ **Date:**_____