PATIENT INTAKE

PATIENT INFORMATION

Name: (First) _____ (Middle Initial) _____ (Last)_____
Preferred Name:_____ Address:_____
City:_____ State:_____ Zip Code: _____
Gender: [ ] Male [ ] Female Age:_____ Birth Date: _____/_____/_____
Month Day Year

Current Member?
[ ] Village Health Clubs [ ] Nonmember

How did you hear about us? [ ]Friend/Relative:_____ [ ]Website
[ ]Physician:_____ [ ]Village Staff or Member_____
[ ]TV [ ]Brochure [ ]Other_____

Phone: (check the best contact phone)
[ ] Home (_____) _____-_____ [ ] Cell (_____) _____-_____ [ ] Work (_____) _____-_____
Email Address:_____

Appointment Reminder Preference: (check the best option)
[ ] Phone [ ] Text [ ] Email

Occupation: _____ Employer: _____
Referring Physician: _____

Parent/Guardian/Spouse
Name_____Relationship_____
Address_____City_____State_____
Occupation_____Employer_____
Work Phone(_____) _____-_____Cell Phone(_____) _____-_____
Home Phone(_____) _____-_____

EMERGENCY CONTACT
In case of an emergency please contact:
Name: _____ Relationship: _____
Phone: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____
Email: _____

Party Responsible for Bill if NOT Patient:_____
Mailing Address:_____ City:_____ State: ____ Zip:_____
Phone (_____) _____-_____ Relationship to Patient: [ ] Spouse [ ] Child [ ] Dependent

Payment/Billing Policies

Please read carefully and initial:

The Body Shop Physical Therapy, PLLC, is a fee-for-service clinic. This means that payment is due at the time services are rendered and we will Not bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose to submit to your insurance company. We accept cash, personal checks, credit cards, and HSA cards.
(Initials:_____)

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Given you will be paying at the time of service, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be cut to your personally.
(Initials:_____)

I understand that The Body Shop Physical Therapy, PLLC, has a 24-hour cancellation policy and a charge of $75 will be billed to me directly if I miss any appointment or fail to provide the required 24-hour notice when canceling an appointment. Only emergencies or illnesses are excusable. I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment.
(Initials:_____)

Privacy Policy

I understand that The Body Shop Physical Therapy, PLLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
(Initials:_____)

I/We authorize The Body Shop Physical Therapy, PLLC, to release all medical information and/or records to my requesting insurance company and/or referring physician.

***X*_____ *Date*_____**

Signature of Patient/Guardian

Medicare

Medicare will Not pay for services rendered at The Body Shop Physical Therapy, PLLC. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean you should not receive it. There may be a good reason your doctor, healthcare provider, or fitness professional has recommended it. Right now, in your case, Medicare will not pay for our services as we are not a Participating Provider with Medicare or any other insurance company, and we only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually possess. Signing your initials means that you have received and understand this notice. You may receive a copy upon request at any time.
(**Initials:**_____)

SIGNATURES

I **certify that the information provided on this form is true and correct to the best of my knowledge. I give my permission for the practitioner to administer and perform such procedures as may be deemed necessary for treatment. By initializing above and signing below, I am indicating that I understand and agree to the above terms and conditions. I have read and completely understand the above written statements.**

X_____ **Date**_____
Patient-Age 18 or older

X_____ **Date**_____
Parent/Guardian- If patient is under age 18

I also Understand that Medicare will not reimburse for services rendered by The Body Shop Physical Therapy, PLLC.

X_____ **Date**_____
Signature of patient