20 Country Club Drive
Downingtown, PA 19335
(610) 518-9100 voice
(610) 518-0992 fax
Brockristy@aol.com

IN MOTION Physical Therapy and Rehabilitation

DATE: _____ PHONE: _____

NAME: _____ CELL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT'S BIRTH DATE: _____/_____/_____ SSN: _____-_____-_____ SEX: M F

INSURANCE SUBCRIBER'S NAME _____ THEIR SSN: _____-_____-_____

ADDRESS: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRING PHYSICIAN: _____ DATE OF INJURY/ACCIDENT: _____
(IF AUTO OR WORK. COMP.)

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ PHONE: _____

_____ CITY: _____ STATE: _____ ZIP: _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

CO-PAY, CO-INSURANCE, DEDUCTIBLE

I UNDERSTAND THAT MY HEALTH INSURANCE MAY HAVE A CO-PAY, CO-INSURANCE, OR DEDUCTIBLE THAT I MAY BE PERSONALLY RESPONSIBLE FOR. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CALL MY MEMBER SERVICES DEPARTMENT OF MY INSURANCE COMPANY TO VERIFY THE SPECIFICS OF MY PHYSICAL THERAPY COVERAGE WHICH MAY DIFFER FROM THE PHYSICIAN COVERAGE.

_____ (INITIALS) _____ (DATE)

ASSIGNMENT AND RELEASE AUTHORIZATION

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH THE COMPANY PRESENTED UPON THE FIRST VISIT AND ASSIGN DIRECT PAYMENT FOR ALL PHYSICAL THERAPY BENEFITS TO IN MOTION PHYSICAL THERAPY AND REHABILITATION FOR SERVICES RENDERED TO MYSELF OR A DEPENDENT.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER PAID OR NOT, BY THE INSURANCE COMPANY. WHETHER THE INSURANCE COMPANY DEEMS THEM MEDICALLY NECESSARY OR NOT. FURTHERMORE, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

I AUTHORIZE IN MOTION PHYSICAL THERAPY AND REHABILITATION TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES REGARDING MY HEALTH CARE AT IN MOTION PHYSICAL THERAPY AND REHABILITATION.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN DATE