New Patient:

/ /
DATE

In Motion Physical Therapy

20 Country Club Drive
Downingtown, PA 19335
Office: (610) 518-9100
Fax: (610) 518-0992
brockristy@aol.com
www.gotoinmotion.com

LAST NAME **FIRST NAME**

STREET ADDRESS **CITY, STATE, ZIP**

PHONE: HOME **PHONE: MOBILE**

EMAIL ADDRESS

/ / Male Female - -

DATE OF BIRTH **SEX** **SSN#** *(if workman's comp)*

INSURANCE SUBSCRIBER'S NAME *(if different from patient named above)*

STREET ADDRESS **CITY, STATE, ZIP**

EMERGENCY CONTACT FULL NAME **RELATIONSHIP TO YOU** **PHONE**

REFERRING PHYSICIAN **DATE OF INJURY/ACCIDENT** *(if auto or workman's comp)*

PATIENT'S EMPLOYER **PATIENT'S OCCUPATION**

EMPLOYER'S ADDRESS *(if workman's comp)* **CITY, STATE, ZIP**

PATIENT'S PHONE AT WORK

CO-PAY, CO-INSURANCE AND DEDUCTIBLE

I understand that my health insurance may have a co-pay, co-insurance or deductible for which I may be personally responsible. I also understand that it is my responsibility to call the member services department of my insurance company to verify the specifics of my physical therapy coverage, which may differ from my 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**