227 CENTRAL AVE | CHRISTIANSBURG
757 UNIVERSITY CITY BLVD. | BLACKSBURG
1480 S. MAIN STREET | BLACKSBURG
1014 CLEMENT ST | RADFORD
www.TOTALMOTIONPT.net

PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____ Phone (H): _____

City: _____ State: _____ Zip: _____ Phone (C): _____

Email: _____ Phone (W): _____

Date of Birth: _____ Gender: (M) (F)

Mailing address (if different than above): _____

Reason for visit: _____

Surgery/Accident/Injury/Onset date: _____

Marital Status: _____ Employed Retired F/T Student

How did you hear about us? Internet Referral Friend Family Other

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

RESPONSIBLE PARTY (if different than patient)

Name: _____ Relationship: _____

Address: _____ Date of Birth: _____

City: _____State: _____ Zip: _____ Phone: _____

Do we have your permission to?

Call/leave a message at home or on cell? Yes No

Include Doctoral Students with your care/treatment? Yes No

Let undergraduate PT's or Interns observe your care? Yes No

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Patient Name: _____ **Date**: _____

AUTHORIZATION, ASSIGNMENT AND RELEASE

I hereby give my consent to the doctors, staff and associates of **Total Motion Physical Therapy** to provide treatment to myself or family member. I understand and agree (regardless of insurance status) that I am responsible for the balance of the account. I, the undersigned certify that I (or my dependent) have insurance coverage and assign any insurance payments directly to **Total Motion Physical Therapy** for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Initial: _____

CANCELLATION/ATTENDANCE POLICY

We ask that you try to attend all scheduled appointments. If you need to cancel, please do so **24 hours** prior to your appointment so this time can be filled by another patient. **"No Show"** appointments (no notice given to our office) will be charged a **$25 fee**. If you **CANCEL** or **NO-SHOW** 3 times during your current episode of treatment you will be removed from our schedule.

Initial: _____

INSURANCE/PAYMENT POLICY

Changes made daily by insurance companies, make it impossible for us to accept the responsibility of knowing exactly your insurance benefits, coverage and financial liability. As a service to you, we will call your insurance company for an estimate of what they will pay. It is important to know that any information given over the phone is not a guarantee, only an estimate. Please provide your insurance information on your first date of service and we will file with your insurance, but it remains the responsibility of the patient to know his/her own plan. We require deductibles, coinsurance or co-pay be paid each visit. I understand/agree, that my account, **if not paid within 30 days of statement date**, will be subject to an 18% interest (APR). There is a $35 service charge on all returned checks

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Initial: _____

HIPPA CONSENT

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Additionally, by signing this form you acknowledge that by presenting yourself as a patient or child you consent for medical care by **Total Motion Physical Therapy**. You hereby grant full authority to Total Motion Physical Therapy to administer and perform any treatments to or upon you as advised, or necessary.

All health information may be shared with _____ Relationship _____

RESPONSIBLE PARTY SIGNATURE _____ RELATIONSHIP _____

WITNESS _____, TMTP REPRESENATIVE