TO ALL PATIENTS

Welcome to Motion Dynamics Physical Therapy, PC

The following are the policies of Motion Dynamics PT. Please read them carefully and notify us if you have any questions. Please sign the bottom indicating that you have read and understood these policies. Thank You.

Scheduling : It is very important to arrive promptly for your scheduled appointment. In the event that you need to cancel or reschedule an appointment, please give us at least 4 hours notice, Failure to cancel or reschedule with out 4 hours notice, you will be charged a fee of **$15.00**. If you should fail to keep your appointment (No Show) you will be charged a fee of **$20.00.**

Prescriptions: Your doctor has ordered Physical Therapy, and from time to time we will need a new RX for therapy. The front desk will inform you when you will need to obtain this from your doctor.

Treatment Sessions: Your rehab program is customized to meet your rehab needs at each visit. Therefore, the length of your session may vary. For the safety of our patients we request that only patients be allowed in the treatment area.

Responsibility for Payment : MDPT will file for payment to your insurance company(s). We will diligently work to have your insurance company over all claims. You will be responsible for ***YOUR CO-PAY/ CO-INS***. **Payment is expected at the time of service**. When you have Co-ins we will agree on an amount per visit and adjust the account when final payment from insurance is received. ***Failure to report any changes in your insurance coverage could make all services your responsibility.***

Unpaid accounts: We will report any unpaid balance after 60 days to a credit agency.

Returned Checks: - A fee of $20.00 will be charged for all returned checks. Patient agrees to pay any charges incurred in the collection of this amount.

I (please sign) _____
have read and understand and agree to the above terms in consideration for treatment by Motion Dynamics Physical Therapy, P.C. Date:_____

Consent for Treatment

Authorization - I hereby authorize the Physical Therapists and Physical Therapist assistants of Motion Dynamics Physical Therapy, P.C. to administer all appropriate treatments allowable under the guise of the New State Physical Therapy practice act and recommended buy my physician(s) for purpose of treatment of my medical condition. * I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

Medicare Patients - I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Release of information - I permit Motion Dynamics Physical Therapy, P.C. to disclose all or part of the above patient's medical record to any person, corporation or agency when required for the collection of benefits or payment of Physical Therapy charges.

Assignment of Benefits - I assign to Motion Dynamics P.T., P.C. all benefits from any corporation, agencies and person for the services, Additionally, I authorize payments of these benefits directly to Motion Dynamics P.T., P.C.

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Patient Consent and Service Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third –party payers.
- Conduct normal healthcare operators such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy prior to signing this consent. I understand that this organization has the right to change is Notice of Privacy Practices from time to time and that I may contact this organization at any time for a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

1) In the event we need to contact you may we leave a message at your home Yes □ No □
2) Can we leave a message on your answering machine Yes □ No □
3) Please leave the name(s) of the designated persons we can leave a message with. _____

_____

Relationship to Patient _____ Date: _____

Witness: _____

MOTION DYNAMICS PHYSICAL THERAPY

• EXCELLENCE IN ORTHOPEDIC MANUAL THERAPY AND SPORTS REHABILITATION •

Insurance Coverage

Date : _____

Dear Mr./ Mrs./ Ms. _____

Welcome to Motion Dynamics Physical Therapy P.C.

We have contacted / Verified your insurance and the following information was obtained and is not a guarantee of payment. If you have any question on this information Please contact your insurance to verify that the information give to us is correct.

Worker Comp □ ***No Fault*** □ ***Medicare*** □ ***Commercial Insurance*** □

Co-Pay $_____ per visit Co-Ins _____% per visit Deductible $_____

Please Note: _____

_____

A referral from your Primary Care Physician is need Yes □ No □

A Letter of Medical Necessity is required for your insurance company Yes □ No □

We have received Authorization from you insurance company for #_____
of visits. We will continue to work with your insurance to extend your authorization as needed. You will be requested to bring in an up dated prescription from your referring Doctor. We thank you in advance for your cooperation in this matter.

Patients Signature:_____ Date _____