

BODYFIT PHYSICAL THERAPY AND WELLNESS

NEW PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____

Birth Date: _____ Age: _____ Sex: M / F SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Referring Physician: _____

Is the injury work or accident related? _____

Emergency Contact: _____ Phone #: _____

Employment Information

Employer / Address: _____

Occupation: _____

Insurance Information

Insurance Company: _____ Policy #: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____

SS # of Insured: _____ Birth Date of Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer of Insured: _____

Authorization to Release Information and Guarantee of Account

I authorize BodyFit Physical Therapy and Wellness, PLLC to bill my insurance company directly, and I authorize payment of benefits directly to BodyFit Physical Therapy and Wellness, PLLC. I authorize BodyFit Physical Therapy and Wellness, PLLC to release medical or other information necessary to process this claim.

I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible and co-payment/co-insurance. I understand that some insurance companies require pre-authorization for treatment or have reimbursement limits on physical therapy treatments. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

I will immediately notify BodyFit Physical Therapy and Wellness, PLLC of any changes in my personal information or in my insurance coverage.

Initial: _____

Direct Access

New York State law allows patients to be seen *without* a prescription for the first 30 days or 10 visits (whichever comes first). Any visits beyond this time period will require a physical therapy prescription from a New York medical doctor (MD), osteopath (DO), podiatrist (DPM), Dentist (DDS or DMD) or Nurse Practitioner (NP). Please check with your insurance company for their specific policy, because some insurance companies still require prescriptions at all times for payment. It is your responsibility to keep track of your visits and to attain necessary prescriptions.

Initial: _____

Cancellation Policy

Once an appointment is made, please remember that this time has been reserved for you. Therefore, you will be charged \$75.00 for missed or cancelled appointments without at least 24 hours advance notification. This fee is not billable to any insurance company.

Initial: _____

I understand and agree to the above policies.

Signature: _____

Date: _____

Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP)

I authorize BodyFit Physical Therapy and Wellness, PLLC to release medical information to my physician(s), insurance companies, and any others who are involved in my care. This information may include reports of diagnosis, treatment, prognosis, recommendations, benefits payable, as well as any other data pertinent to my treatment.

I acknowledge that I have received a copy of The Notice of Privacy Practices. I have read, understand, and agree to these guidelines.

Signature: _____

Date: _____

Name: _____