BODY WORKS
PHYSICAL THERAPY, INC
We Help You Make Your Body Work And Feel Better

4080 Loma Vista Rd., Suite H
Ventura, CA 93003
805-535-4400

New Patient Information

Patient Name:_____

Patient Address:_____

Date of Birth:_____ Male: ☐ Female ☐

Patient Phone Number:_____ Cell:_____

Email:_____ (We send education regarding your diagnosis by Email)

Emergency Contact Name and phone number:_____

Referring MD:_____

Diagnosis:_____

Insured's Name:_____ **Insured's Date of Birth**:_____

Insured's Relationship to patient:_____

Primary Insurance Company Name:_____

Patient's Insurance ID#_____ Group #_____

Secondary Insurance?_____ Insurance Co. Name:_____

Secondary Insurance ID#_____ Group #_____

Primary Insurance Phone Number shown on Insurance Card_____

Secondary Insurance Phone Number shown on Insurance Card_____

Please answer all questions if injury is involved. If a question does not apply to your injury please write N/A for not applicable.

Date of Injury: / / Is injury work related: Yes or No

If work related, who was the employer at time of injury?

Is injury related to an accident? Auto Other?

Are you involved in a lawsuit as a result of this injury? Yes or No

If yes, name and address of attorney:

Name of physician or person who referred you to this office:

I hereby irrevocably authorize payment of medical services rendered to myself or my dependents directly to Body Works Physical Therapy. I also authorize Body Works Physical Therapy to furnish my insurance with full information regarding treatment rendered to myself or my dependents. A Xeroxed copy thereof shall be valid. I also understand that my insurance is billed as a courtesy and that I am responsible for all charges not paid by my insurance within 8 (eight) weeks after the billing date. There will be a finance charge of 1 ½ % for all unpaid balances. I further understand that any supplies given to myself or my dependents may not be covered by my insurance. For this reason it is customary to collect for supplies at the time of service. I understand there will be a $50 fee for any missed visits.

_____

Date Signature of Patient or Responsible Party

BODYWORKS
PHYSICAL THERAPY, INC
We Help You Make Your Body Work And Feel Better
4080 Loma Vista Rd., Suite H
Ventura, CA 93003
805-535-4400

Patient Name: _____

Consent for care and treatment:

I, the undersigned, hereby agree and give my consent for BodyWorks Physical Therapy, Inc. to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information:

I the undersigned, hereby authorize the office of BodyWorks Physical Therapy, Inc. to affix my name to any and all claims or documents as related to any and all health benefits due to me. I authorize the release of any information relating to my health care claims. A photo static copy of this authorization shall be as valid as an original.

Authorization for Assignment of Benefits:

I, the undersigned, hereby assign all medical benefits, to which I am entitled to the office of BodyWorks Physical Therapy, Inc. and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to BodyWorks Physical Therapy, Inc.

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 50 days will be subject to a 15% finance charge, for which I am personally liable.

Cancellation Policy:

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24-hour notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $50.00 for a no-show appointment and or cancellations with less than 24-hour notification. I understand that I will be personally responsible for any cancellation fees.

I have read and fully understand all the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

BODY WORKS
PHYSICAL THERAPY, INC
We Help You Make Your Body Work And Feel Better
4080 Loma Vista Rd., Suite H
Ventura, CA 93003
805-535-4400

Patient Questionnaire

Patient Name	Age	Height/Weight	Today's Date

Medical History

Do You Now Have or Have Had any of the Following

Diabetes	Yes	No	Sensitive to Heat or Ice	Yes	No
High Blood Pressure	Yes	No	Pregnant	Yes	No
Heart Disease	Yes	No	Other Allergies	Yes	No
Heart Attack	Yes	No	Previous Surgeries	Yes	No
Pacemaker	Yes	No	Hernia	Yes	No
Headaches	Yes	No	Seizures	Yes	No
Kidney Problems	Yes	No	Metal Implants	Yes	No
Nervous Disorders	Yes	No	Cancer	Yes	No

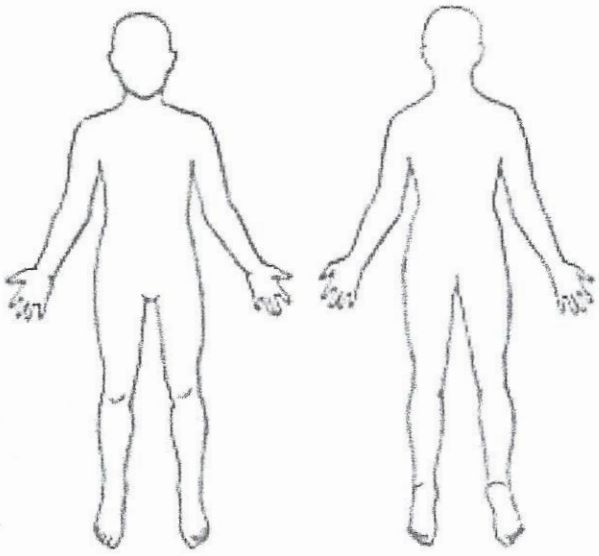
If Yes on any of the above, please explain and give approximate dates

Are you presently taking any medications? Yes No If yes, List what medications and for what condition

Reason for Physical Therapy (include dates and circumstances)

Describe your symptoms and/or complaints

Do you have other problems or concerns we should be made aware of?



Patient Signature Date

BODYWORKS
PHYSICAL THERAPY, INC
We Help You Make Your Body Work And Feel Better
4080 Loma Vista Rd., Suite H
Ventura, CA 93003
805-535-4400

Financial Policy

The changing nature of insurance coverage has forced BodyWorks Physical Therapy to update our Financial Policies. It is important that our patients understand their personal responsibility when receiving medical care. As employers, the Therapists understand the rising cost of health insurance and the complicated nature of the benefits insurance plans pay.

Unless you have medical insurance we will expect payment in full at the time of each visit. We also expect payment in full of copays and co-insurance at the time of the visit. If you have a deductible to meet, we will ask for payment of the deductible at the time of the visit. We try to verify insurance and deductibles prior to each office visit but for same day urgent visits it can be difficult. We look to you the plan holder to educate yourself on your own or family's plan.

For insured patients, it is your responsibility to understand your plan and coverage if you have a deductible or copay or percentage due. We will bill your insurance. Legally, they have 45 working days to adjudicate a claim. If after 60 days, we have not heard from them, we reserve the right to ask your help in getting the claim paid. Once we receive the Explanation of Benefits from your insurance, we will post the payment and bill you for any portion of the charges for which you are responsible. Please understand we have already waited up to 2 months for the payment and/or explanation of why they are not paying. You are responsible to pay your portion as soon as you receive our bill. If you do not pay timely, you will receive notices/statements and telephone calls.

It is never our intention for our billing policy to interfere in the Therapist/Patient relationship. You look to your Therapists for compassionate and appropriate medical care. Our Therapists look to you to follow the treatment plan and to make sure your care is paid for in a timely matter.

Times are economically trying and we are a small Practice that takes pride in the quality and time we give each patient. To operate economically sound if payments are not made timely, we reserve the right to ask you to seek care elsewhere. It is our hope that this never happens.

Your signature on this Financial Policy signifies you understand your ultimate financial responsibility for your or your family's medical care.

_____ _____

Patient Name/Signature Date