PATIENT INTAKE

Record No:	**A/C Type:**
First Name:	**Date of Birth:**
Middle Name:	**Gender:**
Last Name:	**Phone:**
Address:	**Email:**
City: **State:** **Zip:**	**Accident Related:**
Physician Name:	**SSN:**
Primary Insurance:	**Secondary Insurance:**
Emergency Contact:	**Guardian Name (if Minor):**
Are you receiving Home health services now?	**How did you hear about us?**

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: **A/C No:** **Name:**

CONSENT TO TREATMENT: I consent to rehabilitation and related services at THERAPY FIT. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature. _____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY: I understand and agree that THERAPY FIT is not responsible for any loss or damage to personal valuables during the therapy sessions.

_____

WAIVER AND RELEASE: I hereby release, discharge and acquit THERAPY FIT, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liabilities, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive and allow emergency and or medical services, including but not limited to ambulance services, Emergency Medical Technician, Physician or Urgent Care services. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

_____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Signature:_____ **Witness Signature:**_____

Date: _____

This form constitutes propriety information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of THERAPY FIT. This form must be completed in its entirety and must be provided to THERAPY FIT prior to initiation of therapy services.

(Continue on the next page)

Patient Acknowledgement Form

CANCELLATION POLICY

We value you as a patient and want you to receive the maximum benefit from our therapy program. We schedule patients and give specific appointment times so that you can conveniently and efficiently make use of your time. We ask that you do the same for us by keeping your appointment schedule. If you must change your appointment, please do so in advance. Our policy is listed below:

- If throughout the course of therapy, you cancel three appointments without rescheduling, we will ask you to discontinue therapy and we may contact your physician.
- If through the course of therapy, you No Show or No Call three times, we may ask you to discontinue therapy and we may contact your physician.
- If you are more than 15 minutes late for your scheduled appointment time, we reserve the right to ask you to reschedule your appointment.

ASSIGNMENT OF BENEFITS AND CONSENT FOR CARE

I herein assign my right to payment and/or benefits from any/all sources of payment, regardless of whether I am the policyholder, regardless of whether the payment source specifically identifies me as a beneficiary, to and agree to have that payment remitted to Therapy Fit Inc. I herein assign my benefits in exchange for providing a service. I herein give consent to receive treatment from by any therapist or assistant, employee or its agents, as determined by, in conjunction with my plan of care and health care services ordered by an appropriate licensed health care professional.

FINANCIAL RESPONSIBILITY

I herein agree and understand that I am responsible for the cost of care or treatment and that will make reasonable efforts to obtain payment for services. I also agree and understand that any discussion or printed document that is for the purpose of understanding what my payment source will pay is only an estimate based upon information received from my health plan. I understand that defines a health plan to be any entity where they submit claims for payment on my behalf. I herein agree and understand that i am responsible for understanding the amount that is paid from my payment source, even if that amount is zero, regardless of what may have been explained to me by its employees. agents or contractors. I also herein agree and understand that I am responsible for any/all costs of collection, should my account become "delinquent as defined by. including but not limed to late fees, attorney's fees. Court costs or fees paid to a collection agency.

MEDICARE PATIENTS

I hereby certify that the information given by me in applying for payment for Medicare benefits under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Center for Medicare and Medicaid Services, or any of its intermediaries or carriers, any information needed for this or a related Medicare claim I understand that unless I qualify for the cap exception, Medicare will not pay for therapy services that exceed the Medicare allowable caps - which in 2018 is $2.010 for PT/SLP and $2,010 for OT. If services qualify for the exception process, then standard Medicare deductibles and co-insurances will continue to apply toward my charges.

I have reviewed the above information and agree to the terms for treatment at.

_____ **Date:** _____

Signature of Patient or Guardian

Therapy Fit
5350 Independence Pkwy, Ste 110B
Frisco, Tx – 75035
Phone: (972) 587-9404 Fax: (972) 587-9414