New Motion
Physical Therapy Inc., PS

NEW MOTION PHYSICAL THERAPY, INC., P.S.
9419 COPPERTOP LOOP NE
BAINBRIDGE ISLAND, WA 98110
Phone: 206-842-2428 FAX: 206-842-2890

PERSONAL INFORMATION - *Please Print Clearly*

Last Name		First Name	Middle Initial
Date of Birth:	Gender ☐ Male ☐ Female	Marital Status: Divorced Single Married Widowed	
Address:			
City	State:	Zip Code:	Home Phone:
Work Phone:	Cell Phone:	E-Mail:	❑Text reminder- Carrier_____ ❑Email reminder ❑Phone call reminder

Insured (Contract Holder) Information – *Please Print Clearly*

Last Name:	First Name:		
Employer (Company) Name:	Phone:	DOB	Occupation
Employer Address	City:	State:	Zip Code

EMERGENCY CONTACT INFORMATION – *Please Print Clearly*

Name:	Relationship:	
Address (if different than above)		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:

Other Information – *Please Print Clearly*

Date of most recent injury or symptoms:	Body Part Injured:	
Cause: Accident ☐ No Accident ☐ Work Related ☐ Other ☐ State in which accident occurred_____		**How did you hear about New Motion?**
Name of Claim Manager:	Claim Manager Phone Number:	**Claim Number:**

NOTICE OF INFORMATION PRACTICES
(HIPAA – Health Insurance Portability and Accountability Act)

Notice of Information Practices describes how medical information about you may be used and disclosed to your insurance company or your doctor, and how you can obtain access to that information. If you would like a copy of this document, please ask for one.

Federal regulations require that you acknowledge receiving this notice.

The undersigned has received the Notice of Information Practices of New Motion Physical Therapy Services, Inc., PS

X_____ _____
Patient (or guardian if under 18 years of age) Date

Today's Date ___/____/___/_____

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Authorization for Release of Protected Health Information (All patients must sign)

My signature authorizes:

- the verbal and written release of my medical records to my health care provider(s), insurance company and their respective representatives;
- that payment be made on my behalf directly to New Motion Physical Therapy, Inc., P.S. for any services furnished me by NMPT.
- Refer to the statement of Notice of Information Practices for a complete description of uses and disclosures. You have the right to review the Notice of Information Practices before signing this consent.

☐**Patient/Guardian Signature_____ Date: _____**

Please be advised –

Under nationally established standards of practice, every patient must undergo an initial physical therapy evaluation and periodic re-evaluations. However, some insurance companies will not cover re-evaluations and will only cover one initial evaluation or place limitations on the initial PT evaluation. You will be financially responsible for charges associated with the services provided to you. Insurance companies with known limitations:

- Aetna: one initial evaluation every 180 days.
- Premera: one initial evaluation, per diagnosis code, per tax id, every 3 years. Re-evaluation allowed.
- Regence: one initial evaluation, per body part, per lifetime, per tax id. Re-evaluation allowed.

We will place a courtesy call to your insurance company to obtain a summary of your physical therapy benefits. However, your insurance carrier states they are not responsible for the accuracy of this information and that this quote of benefits is not a guarantee of payment. As a result, you will be held financially liable if your insurance company denies payment for services rendered at New Motion Physical Therapy, Inc., P.S. **Therefore, we strongly recommend you verify your benefits by contacting your insurance company.**

Limitations

In order to minimize the chance that your insurance company will reject your claim for physical therapy at our office, we request you provide the following information. Your policy may have specific limits of coverage and therefore, we ask these questions to help uncover any potential limitations with your specific insurance plan. Failure to respond accurately may result in your insurance company denying payment, thus you will be held financially responsible for services rendered to you by New Motion Physical Therapy, Inc., P.S.

Have you received physical therapy in **this calendar year**?_____
If so, for what diagnosis code or body part? _____
About how many visits did you attend?_____
Have you had occupational, massage, speech or acupuncture therapy in **this calendar year**? _____
About how many visits did you attend?_____

I understand that I am responsible for the contract between my insurance company and myself. NMPT will bill my insurance company directly. NMPT will send a patient statement out after claims have been processed by my insurance company. Payment to NMPT is due upon receipt of the statement. I will be financially responsible for all denied or delayed claims. NMPT accepts cash, checks, VISA and Master Card as forms of payment. Interest and Penalties may be applied to accounts greater than 30 days past due.

Patients with additional insurance coverage may request a HCFA 1500 form to submit for reimbursement from their secondary or tertiary insurance carriers for dates of service paid in full – **New Motion does not bill secondary or tertiary insurance carriers.**

☐ *A $100 fee is charged for cancellation with less than 24 hours notice, and for No Shows*

Patient Signature_____ Date: _____

Medicare Only *I request that payment of authorized Medicare benefits be made on my behalf to New Motion Physical Therapy (NMPT) for any services furnished me by NMPT. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-150 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.* ***I am in receipt of the Medicare Patient Information Sheet***
WE DO NOT BILL MEDICAID (APPLE HEALTH)

Patient Signature_____ Date: _____

Today's Date ___/____/___/_____