BODY ZONE™
PHYSICAL THERAPY

3103 Paper Mill Road • Wyomissing PA 19610
610-376-2100 • FAX 610-750-5806 • bodyzonesports.com/pt

PATIENT INFORMATION

PLEASE CHECK ONE: ☐ NEW PATIENT ☐ RETURNING PATIENT ☐ UPDATING INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST) _____

ADDRESS: _____ EMAIL: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED CONTACT NUMBER: HOME _____ CELL _____

DATE OF BIRTH (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER (OPTIONAL): _____ - _____ - _____

MARITAL STATUS
(PLEASE CHECK RELEVANT STATUS): ☐ SINGLE

☐ MARRIED SPOUSE'S NAME (FIRST/LAST): _____

☐ DIVORCED / WIDOWED SPOUSE'S DATE OF BIRTH (MM/DD/YYYY): _____

REFERRING PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: _____ CONTACT NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY/ID # _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH (MM/DD/YYYY): _____

GROUP/ACCOUNT #: _____ EMPLOYER: _____

WORK PHONE: _____

SECONDARY INSURANCE: _____ POLICY/ID # _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH (MM/DD/YYYY): _____

GROUP/ACCOUNT #: _____ EMPLOYER: _____

WORK PHONE: _____

90-DAY COMPLIMENTARY WELLNESS & AQUATICS MEMBERSHIP

With the mission of helping you reach your full potential, new Body Zone Physical Therapy patients and a family member or special caregiver (who are non-members) are invited to enjoy Body Zone's fitness and aquatics centers with complimentary 90-day memberships.

☐ Yes! I would like to receive my complimentary 90-day Body Zone membership.

Name of second membership holder is: _____

☐ No, I am not interested at this time.

Details:

1. A Body Zone Member Advisor will be contacting you to activate your memberships.
2. A Body Zone "Guest Information Form" must be completed for both you and your additional membership holder.

OVER

CONSENT AND ACKNOWLEDGEMENT

CONSENT: I hereby consent to physical therapy and incidental medical services to be provided by Body Zone Physical Therapy.

LIABILITY: I understand and agree that Body Zone Physical Therapy will not be responsible for loss or damage to my personal properties or valuables while I am on the premises of Body Zone Physical Therapy.

RELEASE OF INFORMATION: I allow Body Zone Physical Therapy to provide information to any third party payors or those hired by the third party payors which may be partially or wholly responsible for payment of my physical therapy bill. I allow Body Zone Physical Therapy to release information to BMS Practice Solutions on my behalf for billing of the said third party payors. I also allow Body Zone Physical Therapy to release my information to the provider or office of provider from which I was referred.

INSURANCE: We have an excellent record of getting clients reimbursed for their care. In order to achieve the best possible results for our clients and maintain our industry leading standard of care, Body Zone Physical Therapy expects payment of Co-pays at the time when services are rendered. Patient is fully responsible for knowledge of his/her own insurance benefits and reimbursement policies. Body Zone Physical Therapy will still submit all the claims to the insurance company on your behalf to ensure you receive maximum reimbursement.

DURABLE MEDICAL EQUIPMENT(DME) AND SUPPLIES: Some DME and supplies are not reimbursable by insurance companies and must be paid for prior to ordering.

FINANCIAL POLICY: Thank you for choosing Body Zone Physical Therapy for your physical therapy needs. Please review the following policy regarding financial responsibilities for your care.

PATIENT RESPONSIBILITY:

- All copays, coinsurance, and self-pay balances are due at the time of service.
- Insurance and Personal information provided must be accurate and up to date.
- Please provide 24 hour notice for all cancellations.
- A $35 fee will be charged for any returned check unpaid by your financial institution.

I have read the policy as written above and I agree to the terms and conditions outlined within this policy. Furthermore, I agree to assign all health insurance benefits directly to Body Zone Physical Therapy. I agree to accept full financial responsibility for medical expenses incurred at Body Zone Physical Therapy. I recognize that the terms of this agreement are confidential between myself and Body Zone Physical Therapy.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

MEDICARE PATIENTS

MEDICARE CAP ACKNOWLEDGEMENT *(SKIP TO THE NEXT SECTION IF YOU DO NOT HAVE MEDICARE)*

The Balanced Budget Act of 1997 instituted an annual Medicare payment cap on outpatient physical, speech and occupational therapy services. This cap quickly became a problem for many beneficiaries with long term conditions. A moratorium was placed on the cap, and extended through December 31, 2002 by Medicare, Medicaid, and SCHIP Benefits Improvement and Protection act of 2000 (BIPA). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 placed another 2-year moratorium on the Medicare payment cap on outpatient physical, speech and occupational therapy services. Congress passed a hard therapy cap starting January 1, 2018. The cap amounts are $2010 for physical therapy and speech language pathology combined and another $2010 for occupational therapy, with another $990 when medically necessary per calendar year.

I have read the policy as written above and I agree to the terms and conditions outlined within this policy. Furthermore, I agree to assign all health insurance benefits directly to Body Zone Physical Therapy. I agree to accept full financial responsibility for medical expenses incurred at Body Zone Physical Therapy. I recognize that the terms of this agreement are confidential between myself and Body Zone Physical Therapy.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____