MÕTUS
PHYSICAL THERAPY

HIPAA PRIVACY NOTICE

Please check one:

☐ I acknowledge receipt of a copy of the Notice of Privacy Practices (Please request a copy from the front desk)

☐ I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information with:

Name: _____ **Relationship** _____

Name: _____ **Relationship** _____

POLICY REGARDING CONSENT FOR TREATMENT AND BENEFITS

By signing below:

- I hereby consent to the evaluation and treatment (or the evaluation and treatment of my dependent) at Motus Physical Therapy.
- I authorize all available medical insurance benefits be directly assigned to Motus Physical Therapy & Affiliates for services rendered.
- I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this signed and dated document is considered as valid as the original.

Patient Name (Please Print) _____

Parent or Authorized Representative (if Applicable) _____

If you need to cancel or reschedule an appointment, please call 24 hours in advance. Repeated 'no shows' or cancellations less than 24 hours in advance may result in a $50 fee or cost of a typical appointment.
Initial _____

As a courtesy to our patients, we will complete and file insurance forms relative to physical therapy. However, our professional services are rendered to you, not to the insurance company. YOU ARE DIRECTLY RESPONSIBLE TO US FOR THE OBLIGATION OF PAYMENT FOR TREATMENT.
Initial _____

TREATMENT AT OTHER FACILITIES

If you have received or are currently receiving physical therapy or other related treatment at another facility, you are responsible for informing Motus Physical Therapy, as well as tracking your visit/benefit limit. Treatment received at another facility may affect the number of visits or benefits available to you through your insurance plan and may impact your visit limit with Motus Physical Therapy. Please notify our office of any treatment you have received or are receiving at another facility.

Initial _____

There will be a $35 NSF fee charge, or the amount of the bank charge, whichever is greater for a check returned to Motus Physical Therapy.
Initial _____

PATIENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have reviewed and understand the information provided on this form.

Patient / Authorized Representative Signature _____ **Date** _____