MOTION PHYSICAL THERAPY

25216 GROGANS PARK DR. THE WOODLANDS, TX 77380
PHONE: 281-881-7099 FAX: 281-357-5499

Date_____ Please provide us with your Texas Driver's License and Insurance Card(s)

Patient Information

Name_____ Date of Birth:_____ Age_____ Sex: M F

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Mobile Phone #_____ S.S.#_____

Employer_____ Work Phone #_____

Emergency Contact Person _____ Phone # _____

Primary Care Physician:_____ Pharmacy:_____ Phone#_____

How did you find out about us? _____ Email:_____

Insured's Information

Policy Holder's Name_____ Relation_____ Date of Birth _____Sex: M F

Address (if different from above**)_____ City_____ State _____ Zip_____**

Home Phone #_____ S.S. #_____ TDL#_____

Employer_____ Work Phone # _____

Insurance Information

***Primary Insurance*_____ Policy #_____ Group #_____**

Name of Insured_____ S.S.#_____ DOB_____

Insurance Address _____ Insurance Phone #_____

***Secondary Insurance*_____ Policy # _____ Group # _____**

Name of Insured_____ S.S. #_____ DOB_____

Insurance Address_____ Insurance Phone #_____

PLEASE TURN PAGE OVER TO CONTINUE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Motion Physical Therapy the amount due on my claim, for services to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expenses, I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. A photocopy of this agreement shall be considered as effective and valid as the original.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Motion Physical Therapy to release any medical information acquired in the course of my examination or treatment as may be necessary for the completion of my insurance claims to any insurance carrier, hospital or health plan.

CANCELLATION POLICY

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $35.00. This fee will be paid at the time of my next appointment. Motion Physical Therapy reserves the right to terminate my treatment if I cancel my appointments with unreasonable frequency and/or without proper notice. (init.)_____

DISCLOSURE

I understand that I am a patient of Motion Physical Therapy which is a subsidiary of Center for Spine, Sports & Physical Medicine, P.A. My care is the exclusive responsibility of physical therapy practitioners at Motion Physical Therapy, as well as any other practitioners who also practice at this location.

☐ **I am not receiving any Home Health Care at this time, nor will I receive Home Health Care while I am receiving outpatient Physical Therapy.**

NOTICE CONCERNING COMPLAINTS

Complaints regarding non-compliance with the Physical Therapy Compliance Act, or regarding any licensee under the act, should be directed to the Texas Board of Physical Therapy Examiners at 1-800-821-3205.

Patient (Guardian) Signature Date

Guarantor Signature Date