BodyRenovation
ADVANCED TECHNIQUES IN PHYSICAL THERAPY

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2020 Cheyenne Ct, Grafton, WI 53024
4927 N Lydell Ave, Glendale, WI 53217
10590 N Port Washington Rd, Mequon, WI 53092

PATIENT REGISTRATION

Patient Name_____ Date of birth _____

SSN _____ Sex M F Marital Status _____

Home Phone _____ Cell Phone _____ Work phone _____

Home Address: _____ City _____ State ___ ZIP _____

Email _____

Where did you hear about us? _____ Can we contact him/her to say "thanks?" Yes No

Guardian (if applicable) _____

Relationship _____

Address _____

Phone # _____

Referring Doctor _____

Next visit _____

Circle if applicable:

Worker's Compensation Liability

Primary Insurance _____

Insured _____

Policy# _____

Policy Group # _____

Insured DOB _____

Relationship to patient _____

Secondary Insurance _____

Insured _____

Policy# _____

Policy Group # _____

Insured DOB _____

Relationship to patient _____

HIPAA COMPLIANCE: I have been made aware of Body Renovation's HIPAA Compliance. I give permission to release treatment and any related therapy information to said authorized person(s):

Name/phone _____ Name/phone _____

BODY RENOVATION PHYSICAL THERAPY, S.C. POLICIES

- All services are ultimately charged to you. If payment is not timely for any reason, you are responsible.
- VERIFICATION OF BENEFITS IS ONLY A QUOTE. We do not accept responsibility for settling disputes with any carrier.
- Payment of account balances are due upon receipt. We hold the right to add 20% interest on any balance balance due when litigation is required to satisfy the account.
- We require 24-hour notice for all cancellations. A **$50 fee** will be charged to any appointment canceled within 24 hours and not rescheduled. Our **current cash rate** will be charged for any appointment where there is no notification for unattended visits.

CONSENT, AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS: All information given here is correct. I understand that Body Renovation Physical Therapy may record medical/other data pertaining to my care, which is available to other health care providers. I understand the confidentiality of my records will be protected in the release of data for financial/quality assurance audits and program evaluation reviews. I authorize Body Renovation Physical Therapy to release as required, information pertaining to my care to insurance companies, employer groups and health plans, for the purpose of reimbursement. I authorize Body renovation Physical Therapy, upon agreement, to accept assignment with my rights/claims for reimbursement for expenses allowable under Medicare, Medicaid and any other health plan. In consideration for all medical and hospital services provided by Body Renovation Physical Therapy, S.C., I agree to pay all charges made for such services.

Patient/guardian signature _____ Date _____