NEW PATIENT INTAKE

Onset of
Issue:_____ Symptoms: _____ Initial Appt: _____
Date/Time/Provider

FIRST NAME	LAST NAME	MI	BIRTH DATE	PHONE: Cell Hm Wk
ADDRESS	CITY	STATE	ZIP CODE	PHONE: Cell Hm Wk
REFERRED BY:	STUDENT/MINOR YES ☐ NO ☐		EMAIL ADDRESS	
ANY PREVIOUS PT APPTS IN PLAN YEAR	**ARE YOU CURRENTLY RECEIVING IN-HOME REHABILITATION?** YES NO			

INSURANCE

METHOD OF PAYMENT (CIRCLE) SELF HEALTH INSURANCE PIP WORKER'S COMP LAWYER OTHER:			
PRIMARY INSURANCE	POLICY/ MEMBERSHIP NUMBER GROUP NUMBER		PHONE
GUARANTOR NAME (IF STUDENT/MINOR)	RELATION TO PATIENT	BIRTH DATE (GUARANTOR)	START MONTH/PLAN YEAR
SECONDARY INSURANCE	POLICY/MEMBER NUMBER GROUP NUMBER		PHONE

BENEFITS (for office use only)

DEDUCTIBLE	MET: YES NO	CO-PAY	CO-INSURANCE
PRE-CERT NEEDED YES NO	NUMBER OF VISITS PER YEAR	ORTHOTICS COVERED YES NO	NUMBER OF VISITS USED

MVA RESPONSIBLE PARTY INFORMATION

AUTO INS CO.	ADDRESS	PHONE
CLAIM#	ADJUSTERS NAME	
ATTORNEY	ADDRESS	PHONE

PATIENT/CLIENT RESPONSIBILITES

Megan Rich Physical Therapy (MRPT)

I agree to actively participate in my therapy program, including but not limited to the following:

- Being prompt to my appointments/classes, signing in, paying co-pays, balances, drop in rates upon arrival.
- Being discharged and referred back to my physician if I "no show" or cancel three (3) consecutive appointments. All future scheduled appointments will be cancelled.
- Complying with a mutually agreed upon treatment plan.
- Providing feedback to my therapist regarding my well-being and taking responsibility to improve my condition.
- **Giving 24-hour notice to cancel MRPT appointments. Without 24-hour notice, you will be charged $30.00 per 30 minute PT appointment and $75 per 60 minute appointment.**

_____ _____
SIGNATURE OF PATIENT/GUARANTOR **DATE**

Megan Rich Physical Therapy
9492 Deereco Road, Timonium, MD 21093
Phone (410)308-7182; Fax (410) 308-7179; www.meganrichpt.com

CONSENT TO PARTICIPATE IN MOVEMENT THERAPY and/or RECEIVE PHYSICAL THERAPY SERVICES

MRPT has made available facilities and equipment for the benefit of its clients. This document will help you understand the risks associated with participation so that you may make an informed decision with regard to your participation.

Risk: If you elect to use the fitness area or any portion of this facility or if you elect to participate in any related programs, your use and participation will be solely **at your own risk**. You are advised to consult with your personal physician before beginning to use the fitness area or participating in any related activity. In addition, if deemed advisable by your physician, you should consult with him/her on an ongoing basis. Trainers/teachers/therapists are trained in fitness program management, but are not physicians. Trainers/teachers/therapists lease space used as the fitness area and are in no way owners. You should not view their assistance, or any results of any exercise assessments, as medical diagnosis or statement about your health. Moreover, the trainer/teacher/therapist will not be responsible for monitoring individual use of the fitness area, but will provide assistance. Even consultation with your physician and engaging in regular exercise in no way guarantees against the possibility of adverse occurrences during exercise sessions or use of other fitness area facilities. Possible risks include, but are not limited to, episodes of dizziness, fainting, muscle and skeletal injury, sprains, heart attack, stroke, or sudden death. Please contact your physician for further details.

Release: As a condition precedent to your right to use the fitness area and participate in programs offered, you must sign below. Please read this form carefully and make sure you fully understand it before signing.

Signature: I have read and understand the descriptions and risks described herein. Any questions that have occurred to me have been raised and have been answered to my satisfaction. I consent to receive training rendered at the BMI and physical therapy at MRPT.

_____ _____

SIGNATURE OF PATIENT/GUARANTOR **DATE**

PATIENT AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I _____, hereby authorize MRPT to apply for benefits from _____ for payments to be made directly to MRPT. In the event that MRPT is not a provider of care with your insurance carrier then I agree to pay directly at time of service for the session(s). MRPT will supply me with the bill including the diagnosis code, CPT codes, or other so I can submit the bill myself for reimbursement. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this and any related claim, to the named insurance company. I permit a copy of this authorization to be used in place of the original. Either the above carrier or I may revoke this authorization at any time, if in writing to MRPT. I hereby authorize payment of medical benefits directly to MRPT, if any otherwise payable to me for services described by the therapist's billing information. I understand the limits of my insurance company(s) and/or Medicare. **I understand that I am financially responsible for all charges not covered by this authorization including balances due after 60 days of billing, as well as any co-payments and deductibles as per the terms specified by my insurance carrier paid in full at the time of services. If for any reason the workers' compensation claim is found non-condensable, I will accept full responsibility for any charges incurred. I understand that durable medical equipment (DME) is paid for at the time of purchase and is not returnable or refundable. I understand that I will be charged $30.00 per 30 and $75.00 per 60 minute appointments if 24-hour notice is not given prior to not showing, canceling or rescheduling.**

_____ _____

SIGNATURE OF PATIENT/GUARANTOR **DATE**

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care options (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. By signing below, I acknowledge I have access to a full copy of this Notice of our Privacy Practices. I also acknowledge that my information may be shared with non-healthcare professionals employed by MRPT for purposes of providing care in the continuum of services.

_____ _____

SIGNATURE OF PATIENT/GUARANTOR **DATE**

POOL WARM-WATER WAIVER

MRPT maintains a therapy pool water temperature of 90-92 degrees Fahrenheit. Research shows that for an active, recreational water exercise program that incorporates flexibility, stretching, muscle strengthening and endurance activities, the appropriate and safe water temperature range is 83-90 degrees Fahrenheit. Ill effects that may occur in higher water temperatures include increased core body temperature, blood pressure changes, increased oxygen consumption, cardiac demands beyond a safe margin and increased risk of cardiovascular incidents for people with chronic health conditions. Please sign below indicated that you have read and understand the descriptions and risks described herein and also acknowledge there is **NO LIFEGUARD ON DUTY**.

_____ _____

SIGNATURE OF PATIENT/GUARANTOR **DATE**