



Movement for a better life.

Welcome to MotionCare

Your Individual Information

Onset of pain or injury? / /

Your Name (first middle last)		Date of Birth	Gender M / F	Social Security Number
Home Address		Home Phone ()		
City	State	Zip	Cell Phone ()	
Employer		Work Phone ()		
Employer Address		City	State	Zip
In case of emergency, call local contact		Phone ()		

Personal Health Insurance Information

PRIMARY Insurance	Group Number	Identification Number		
Name of Insured	Address of Insured, if different	Relationship to Insured Self / Spouse / Child / Other	Date of Birth of Insured	
Insured Social Security Number	Employer / Address	Phone H ()	W ()	

SECONDARY Insurance	Group Number	Identification Number		
Name of Insured	Address of Insured, if different	Relationship to Insured Self / Spouse / Child / Other	Date of Birth of Insured	

Motor Vehicle/Personal Injury Information

Motor Vehicle / Personal Injury Carrier	Claim Representative's Name	Claim Number		
Address	City / State / Zip	Phone Number ()	Fax Number ()	
Name of Insured	Address of Insured, if different	Relationship to Insured Self / Spouse / Child / Other	Date of Birth of Insured	
Attorney's Name	Attorney Address	Attorney Phone Number ()	Fax Number ()	

Worker's Compensation Information

Insurance Carrier	Claim Representative's Name	Claim Number		
Address	City / State / Zip	Phone Number ()	Fax Number ()	
Employer	Occupation			
Address	City / State / Zip	Phone Number ()	Fax Number ()	
Attorney's Name	Attorney Address	Attorney Phone Number ()	Fax Number ()	

We cannot guarantee coverage by your insurance carrier. Your information will assist us in determining if some of the expenses are reimbursable by your insurance carrier. I certify that all the information entered above is true and correct to the best of my knowledge and will keep MotionCare apprised of any changes to this information.

Signature _____ Date _____ Initials _____ Date _____
 Signature _____ Date _____ Initials _____ Date _____

BELOW FOR OFFICE USE ONLY

Coverage—Health Ins/MVA/Personal Injury/PVT/WC
 Physician _____ Onset _____
 Code: _____ MD DX: _____
 Code: _____ TX DX: _____
 Code: _____ TX DX: _____

Site: 1 2 3 Keyed _____
 NP/NOP/Change of Ins/ Chg of MD/Chg of DX
 Therapist _____
 Copay _____
 Acct number _____



MotionCare

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FINANCIAL and RELEASE INFORMATION

A. TREATMENT AUTHORIZATION

I hereby authorize and consent for MotionCare to treat the condition as they deem necessary and appropriate.

Date

Initial

B. GUARANTEE OF ACCOUNT

As a courtesy, MotionCare will file claims for benefits with your insurance company. MotionCare will furnish you with a statement of account showing the amounts billed and payments or credits applied to your account.

I understand that I am responsible for the charges for all services rendered toward myself, or the patient, by MotionCare. As the patient/parent/guardian, I understand that I am personally responsible to ensure payment on any account balance within 30 days of services rendered. If for any reason insurance does not pay for a portion or all of my account claim, I will make prompt arrangements to pay the account myself.

I understand that a MotionCare account becomes past-due after 120 days. I further understand that if I neglect to make payment on a past-due account, MotionCare will use an attorney for collection and that I am personally responsible for the reasonable costs of collection. I also understand that MotionCare has the right to charge an interest rate of 6% on all past-due accounts.

I understand that it is my responsibility to obtain pre-authorization for treatment, if required by insurance, and that I am responsible for any charges insurance does not pay because pre-authorization was not obtained. I further understand that co-payments or other payments that insurance plans do not cover for services rendered by MotionCare are due at the time of service.

Payments to MotionCare may be made in cash, by personal check, or on a MasterCard or Visa. I understand that personal checks returned without sufficient funds will result in a \$15.00 fee.

I acknowledge that I have received or have been offered a copy of the MotionCare Financial Policy. I further acknowledge that I have the right to receive a copy of the MotionCare Financial Policy at any time upon request.

Date

Initial

C. RELEASE OF INFORMATION: Insurance Carriers, Other Providers

I authorize MotionCare to release necessary information needed to process claims and obtain payment for services rendered by MotionCare on behalf of the patient and/or dependents. Furthermore, I authorize MotionCare to release patient health records to any provider who is being advised or consulted with connection to the patient's current treatment and care management.

Date

Initial

D. ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled for physical therapy at MotionCare including but not limited to Medicare and other government sponsored programs, private insurance, and other health plans benefits payable for motor vehicle accidents and workers' compensation, etc. to MotionCare, Shoreview Medical Center, 4625 Churchill St., Suite 204, Shoreview, MN 55126.

I authorize MotionCare to endorse co-insured remittances for convenience in crediting benefit payments made to my account.

Date

Initial

E. PATIENT PRIVACY

I acknowledge that I have received or been offered a copy of the MotionCare Patient Privacy policy. I have the right to receive a copy of these privacy practices any time upon request. MotionCare complies with all State and Federal regulations regarding Patient Privacy.

Date

Initial

F. MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to MotionCare for any services rendered me.

I authorize any holder of medical information about me be released to Medicare & Medicaid Services and its agents for determination of these benefits or the benefits payable for related services.

Date

Initial

I give my consent for a photocopy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize MotionCare to release all information necessary to secure the payment of benefits.

Patient/Spouse/Parent/Guardian Signature _____ Date _____

Printed name of the above signature _____

Relationship of signer, if other than Patient _____