Welcome to MotionCare®

Your Individual Information

Patient Full Name

Onset of pain or injury (required) | Gender (M/F) | D.O.B | Social Security Number

Home Address | Home Phone

City | State | Zip | Cell Phone

Employer | Work Phone

Employer Address | City | State | Zip

In case of Emergency contact name | Phone

Health Insurance Information

Primary Insurance | Group Number | Identification Number

Name of Insured | Address of Insured (if different) | Relationship to Patient (Self / Spouse / Parent / Other) | D.O.B of Insured

Insured Social Security Number | Employer/Address | Home Phone | Work Phone

Secondary Insurance | Group Number | Identification Number

Name of Insured | Address of Insured (if different) | Relationship to Patient (Self / Spouse / Parent / Other) | D.O.B of Insured

WC / MVA / Personal Injury

Claim Type: Workers Compensation | Motor Vehicle Accident | Personal

Claim Representative's Name

Insurance Company | 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__________________

For Office Use Only

Coverage— Health INS/SELF/MVA/WC/Personal Injury

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____

5985 Rice Creek Parkway #104, Shoreview, MN 55126
PH: (651) 484-6735 FX: (651) 484-5663
E-mail: clinics@motioncare.com www.motioncare.com

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: Initials:

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: Initials:

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: Initials:

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, ect. 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: Initials:

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: Initials:

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: Initials:

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____________________