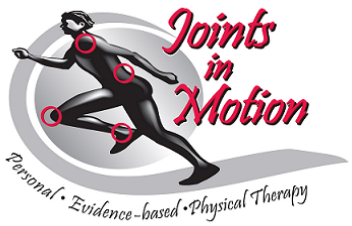


Welcome

Thank you for choosing Joints in Motion Physical Therapy as your healthcare provider. Please remember to bring your completed New Patient Paperwork along with your insurance identification card and driver's license or state issued ID. It is important that you **arrive 15 minutes early** to complete patient check-in. Late arrival or failure to have all of your paper work completed for your appointment may result in it being rescheduled.

If your insurance company requires a referral to see a specialist, you must bring the referral to your appointment or verify that our office has received the referral. If you are not sure whether or not you need an authorization or referral you should contact your primary care physician's office. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company.

At the time of your visit, you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate and for any services that are not covered. Payments can be in the form of cash, check or credit card.

We look forward to serving you. Should you have any questions, please call us at 972-539-5795 so we may assist you.

3301 Long Prairie Rd, Ste 125
Flower Mound, Texas 75022
Tel: (972) 539-5795
Fax (972) 539-5793
www.jointsinmotionpt.com

NEW PATIENT INFORMATION

Patient Name: _____ Social Security #: _____-_____-_____

Address: _____ City/State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Date of Birth: _____/_____/_____ Sex: ☐Female ☐Male Marital Status: _____

Email Address: _____

Employer: _____ Occupation: _____

Employers Address: _____ City/State: _____ Zip: _____

Insurance Name: _____ ID#: _____

Name of Primary Insured: _____ Insured's DOB: _____/_____/_____

Primary Insured's SS#: _____-_____-_____ Relation: _____

Primary Insured's Employer: _____ Group #: _____

Emergency Contact: _____ Phone #:_____ Relationship:_____

Referring Physician: _____ Primary Care Physician: _____

Area of Injury: _____ Onset/Injury/Surgery Date: _____

MEDICARE PATIENTS: Are you currently enrolled in Home Health? Yes or No
*If Yes, you cannot receive outpatient physical therapy until you have been discharged from your Home Health Episode.

Consent to Treatment: I hereby grant ED Huffman Enterprises LLC., d/b/a Joints In Motion, PT the authority to evaluate and treat me/my dependent and order the examination, test, treatment and other clinical services necessary for my care and treatment.

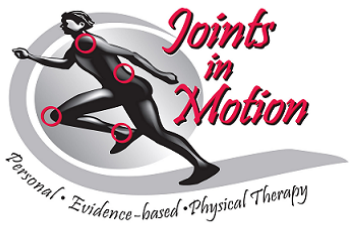
Release of Information & Assignment of Benefits

All information provided herein is true and correct.

I give permission to Joints In Motion, PT to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employers, school, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

I request that payment under my medical insurance program be made to Joints In Motion PT. for any services furnished to me. I also request that a copy of this authorization be used in place of the original.

Signature of Patient/Guardian: _____ Date: _____



Acknowledgement of Receipt of Notice of Privacy Practices and Office and Financial Policy

I, _____, acknowledge I have received the office Privacy Policy and Office and Financial Policy for Joints in Motion Physical Therapy. I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I HAVE, HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____

Signature of Patient/Guardian Date

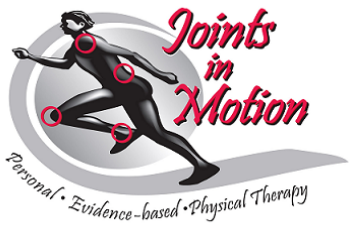
Please add any persons with whom we may discuss your medical history and current treatment.

_____

_____

_____

_____



3301 Long Prairie Road
Suite 125
Flower Mound, TX 75022
972-539-5795
972-539-5793-fax

Cancellation and No Show Policy

At Joints in Motion, we understand that all of our patients' time is valuable. So, help us help you by keeping your scheduled appointments.

If you need to reschedule or cancel your appointment, please do so a minimum of 24 hours prior to your scheduled appointment.

Patients who do not cancel or reschedule their appointments may be subject to a fee of $35.00. Our office will make reasonable attempts to confirm appointments one to two days in advance.

It remains the patient's responsibility to keep or reschedule appointments in compliance with the above policy. Exceptions will be made for medical or family emergencies. Please note, insurance companies cannot be billed for missed appointments.

I have read, understand and agree to comply with the above policy.

Patient Name (Print)

Patient Signature Date