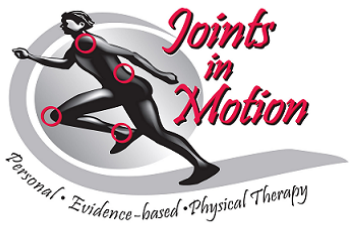


Welcome

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

PATIENT INFORMATION UPDATE

Patient Name: _____ *SSN:* _____

Address: _____ *City/State:* _____ *Zip:* _____

Home #: _____ *Cell #:* _____

Date of Birth: _____ *Sex:* _____ *Marital Status:* _____

Email: _____

Employer: _____ *Occupation:* _____

Insurance _____

*Emergency Contact/Tel:*____ _____

Referring Physician: _____ *PCP:* _____

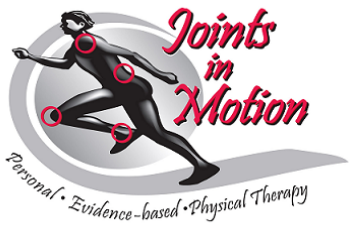
HIPAA and Practice Policies Consent

Due to the health insurance portability and accountability act, our office is now required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office reception room for patients to review. Please sign this as your acknowledgment that this office is following HIPPA policy as well as the Practice policies.

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment, activities, and healthcare operations. You have a right to read our Notice of Privacy Practices before you decide whether to sign this consent. You will have the right to evoke this consent at any time by giving us written notice of your revocation by certified mail.

I authorize the doctor to perform any and all forms of treatment and therapy that may be indicated in connection with the care of the patient above. I also understand that prior to treatment; full explanation of the procedure(s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by this office.

Signature: _____ 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

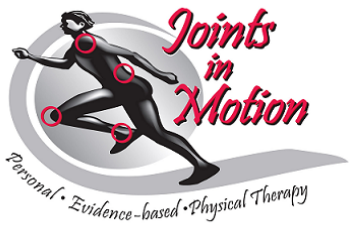
Please add any persons with whom we may discuss your medical history and current treatment.

_____

_____

_____

_____



3301 Long Prairie Road
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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