Date:

_____

Body Technic Systems®, Inc.
www.bodytechnic.com
33200 Bainbridge Rd. Ste D
Solon, Ohio 44139
440-248-9255 phone
440-248-3608 fax

Patient History Information

Name: _____ Date of birth:_____

Address: _____ City:_____

State: _____ Zip: _____ Cell phone: _____

Home phone: _____ Work phone: _____

E-mail: _____

Occupation: _____Employer_____

Referral: _____ Phone: _____
Emergency Contact_____name/phone/mobile and relation to patient

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What is your reason for sessions? __work __sport __trauma __chronic

_____
_____
_____

Have you had either of the following? ____surgery ____therapy

If so, provide the dates: _____

Recent x-rays, MRI's or other tests done? Specify _____

If you had therapy, what type? _____

Who was the therapist/surgeon? _____

Do you have a history of bone, joint, or muscle problems?
_____
_____

Do you have any other medical problems (ulcers, diabetes, cardiac problems, asthma, etc.?

_____
_____

Are you currently taking any medication? _____

Do you have any allergies? _____
Do you exercise regularly?_____

How would you rate your current sleeping habits?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good
Please list any specific sleep problems you are currently experiencing:
Do you follow a particular diet? □ Yes □ No
If so, what type:_____
Do you use tobacco? □ Yes □ No
If so, how often:_____
Do you use alcohol? □ Yes □ No
If so, how often:_____
What hobbies do you enjoy:_____

Health History:
Have you ever had or suffered from any of the following:
Allergies □Yes □No
Asthma □Yes □No
AIDS/HIV □Yes □No
High Blood Pressure □Yes □No
Thyroid Problems □Yes □No
Respiratory Problems □Yes □No
Kidney Trouble □Yes □No
Migraines □Yes □No
Chronic cough □Yes □No
Coughing up blood □Yes □No
Low Blood Sugar □Yes □No
Epilepsy or Neurological Problems □Yes □No
Cancer □Yes □No
Sinus Trouble □Yes □No
Fainting Spells □Yes □No
Diabetes □Yes □No
Hepatitis/Jaundice/Liver Problems □Yes □No
Stomach Problems □Yes □No
Tuberculosis □Yes □No
Sexually Transmitted Disease □Yes □No
Mental Health Problem □Yes □No
Immune System Problems □Yes □No
Congestive Heart Failure □Yes □No
High Cholesterol □Yes □No
Heart Disease □Yes □No
Thyroid Disease □Yes □No
Stroke □Yes □No
Arthritis □Yes □No
COPD □Yes □No
Do you have any allergies to:
Anesthesia □Yes □No
Sulfa Drugs □Yes □No
Narcotics □Yes □No
Penicillin or Antibiotics □Yes □No
Barbiturates □Yes □No
Iodine □Yes □No
Other □Yes □No
If you have other allergies please describe:_____

Payment and Insurance Reimbursement Policy

Please read carefully prior to signing. Once you sign this there will be no refunds in full or in part for any services rendered whatsoever.

1. I agree to receive services from Body Technic Systems®, Inc. for myself or family member.

2. Payment for all services rendered by Body Technic Systems®, Inc. will be made **in full at the time of service** by cash, check, MasterCard, Visa, Discover, or American Express.

3. I understand that Body Technic Systems®, Inc. does not accept assignment of benefits and is not a provider for any insurance company.

4. All fees collected are Non-Refundable.

I choose to use the Body Technic Systems ®, Inc. Billing Services. Yes _____ No _____
Initials _____

5. I understand that my claims will be filed for reimbursement. Body Technic Systems®, Inc. can be contacted about information related to my claim; as we are qualified to do so. If you need us (Body Technic Systems®, Inc.) to inquire about your benefits that your insurance carrier provides, you will need to request this, otherwise it is the responsibility of the insured (patient) to determine what their benefits are, on their own. Remember: we are an out-of-network provider. Your insurance carrier may or may not have reduced reimbursement rates due to this. Always check to see what your plan covers that is/was your choice, and not ours.

I have read and fully accept the above terms and conditions.

_____ _____
Signature Date

_____
(Print full name)

Patient Information Form Date:

Marital status: Single/ Married/ Divorced/Other:_____

Patient last name: _____ Gender: Female/Male (circle one)

Patient first name:_____ Patient SSN: _____

Patient middle name: _____ Employer:_____

Patient nickname: _____ Work-phone: (____)_____-_____ext._____

Mailing address:_____ Cell-phone ( )_____-_____

Street address:_____ Drivers license #_____

City:_____State:_____ Zip_____ Spouse's name: _____

Home telephone: ( ) _____-_____ Father's name: _____

Date of Birth: _____ Mother's name: _____

If you are not responsible for payment, who is? _____

If you do not have insurance, how will you be paying for services? _____

Primary insurance:_____ Is this your policy? Yes/ No (circle one)

Policy number: _____ If not your policy, who is holder:_____

Coverage begins_____ends_____ What is your relationship to the holder_____

Policy holder DOB_____ Policy holder gender: Female/ Male (circle one)

Employer:_____ Work-phone ( )____-_____

Secondary insurance:_____ Is this your policy? Yes /No (circle)

Policy number:_____ If not your policy, who is holder:_____

Coverage begins_____ends_____ What is your relationship to the holder_____

Policy holder DOB_____ Policy holder gender: Female/ Male (circle one)

Employer:_____ Work-phone ( )____-_____

In case of emergency, notify_____ phone:_____

Nearest relative not living with you:_____ phone:_____

Physician's name (if this practice is not your primary care physician):_____ phone:_____

Dentist name_____ Last visit_____phone:_____

I hereby authorize Body Technic Systems®, Inc. to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed either or below.

I authorize payment for these services to be made directly to

I also understand that I am responsible for payment of services not covered by my insurance company and that payments for co-pays is required at the time of service

Signature of responsible party_____date_____

Printed name (if not patient)_____

Other family members	Birth date	Relationship	Is insurance the as above
_____	_____	_____	Yes/ No
_____	_____	_____	Yes/ No
_____	_____	_____	Yes/ No

Advanced beneficiary Notice

Date:_____ Patient Name:_____

Medicare#:_____Provider:L.Sunday Homitz, LPT

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services

We anticipate that your insurance will not pay for the item(s) or services(s) described below. The fact that your insurance may not pay for a particular item or services does not mean that you should not receive it. And, note, that if your physician(s) recommended these item(s), or service(s), your insurance co. may not pay for it.

Service: Physical Therapy
gait training aquatic therapy therapeutic exercises manual therapy
modalities Other:_____
Reason: insurance limits how much, how often these procedures may be performed

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing in advanced that you might have to pay for them yourself. Before you make any decision about your options, you should:
-READ THIS NOTICE CAREFULLY
-Ask us to explain, if you don't understand, why your insurance might not pay.
-Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance. See enclosed rate sheet.

Estimate Cost: $_____

PLEASE CHOOSE 1 AND ONLY ONE OPTION. CHECK ONLY 1 BOX SIGN & DATE YOUR CHOICE. SIGN AND DATE YOUR CHOICE.

☐ OPTION 1. YES, I want to receive these itmes or services. I understand that my insurance company might not pay for these items or services. Please submit my claim to my insurance company. I understand that you may bill me for these items or services, and that I may have to pay the bill, while the insurance company makes its decision. I understand that if my insurance company does pay, they will pay me directly. If the insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal the decision to my insurance company.

☐OPTION 2. NO. I have decided not to receive these items or services. I understand that my doctor recommends these items or services, that I may have to pay for it, and I choose not to have it.

_____ _____

Date Signature of patient or person acting on patient's behalf

Office Policies

1. I understand that payment is due at the time of my visit.
2. I understand that I am financially responsible for any amounts not covered by my insurance carrier.
3. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
4. I understand that a copy of my insurance card must be shown at each visit.
5. I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one, and that if one is not received my appointment will be cancelled.

Release of information Issues

I, with my signature, authorize Body Technic Systems®, Inc. and any employee working under the direction of L. Sunday Homitz, LPT to provide medical care for me. I also authorize L. Sunday Homitz, LPT to furnish information to my identical insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, coinsurance, amounts applied to deductibles, and other amounts that may be deemed responsibility by insurance plan as required by my contract with my insurance plan and state regulation

I also authorize and give consent to L. Sunday Homitz, LPT and other health care professionals associated with her to discuss my care or other relevant information with attorneys, accountants, malpractice carriers, outside consultants, transcription agents, billing agents, and coding specialists as deemed necessary by L. Sunday Homitz, LPT. This includes all services relating to my medical care including: hospital services, nursing home services, lab services, radiology services, and care directly associated with L. Sunday Homitz, LPT. This contract may include ongoing correspondence with referring and consulting physicians for the duration of my care and as needed for continuity of care.

I further understand that my contract with my health care insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

_____ _____

Signature Date

Yearly review

I have reviewed the above information, and there is no change. (Initial below)

_____(2015) _____(2016) _____(2017) _____(2018) _____(2019) _____(2020)

Cancellation Policy

I _____ understand that I must cancel an appointment with Body Technic Systems 24 hours prior to that appointment. I also understand that if proper contact is not made, I will be charged for that appointment.

_____ _____

Signature Date

Fee Schedule*

Physical Therapy

$62.50 per quarter hour / $250 per hour

Payment is due at time of service. We accept cash, checks, MasterCard, Visa, Discovery and American Express.

Optional billing service is available (see "Patient Registration Form for Billing Service" for details).

Note: Evaluation not required prior to care, but recommended, especially if you want to be reimbursed by your insurance company. Remember, your health insurance coverage does not cover fitness training classes, private or semi-private sessions.

All fees collected are Non-Refundable.

Personal Training Service / Fitness Classes

	Sunday Homitz, LPT	Certified Instructor	Student Instructor
1 session (1 hour per person)	$125	$85	$70
5 sessions package (1 hour per person)	$550	$375	$300
10 sessions package (1 hour per person)	$950	$650	$550

Notes:
_____
_____
_____

*All fees are subject to change.
*All fees collected are Non-Refundable