167 Avenue at the Common Suite One
Shrewsbury, NJ 07702

Patients Name: ________________________________ Date of Birth___________

Consent for treatment:
I acknowledge that I am in need of physical therapy and do hereby voluntarily consent to such care rendered by Dean Thompson DPT, Lisa Sullivan, MPT, Christine Bevacqua, PT or Christine Rogerson, PT.

I understand that as Care in Motion, Physical Therapy, LLC is an Out of Network provider, it is my responsibility to check my benefits and authorization requirements prior to initiating treatment. Care in Motion, Physical Therapy, LLC will bill Medicare and all secondary plans as well as Aetna Managed Medicare plans only.

I further acknowledge that I am responsible for all charges not paid by my insurance company, and personally guarantee payment in full.

Patient's Signature: ________________________________ Date: ____________

Authorization To Release Information and Assign Benefits

I authorize Care in Motion, Physical Therapy, LLC to release any pertinent information about me to my doctor(s), any person listed below, or any agency or its intermediaries or carriers needed for this or a related claim. I authorize and assign payment for authorized benefits to be made on my behalf directly to Care in Motion, Physical Therapy, LLC. I acknowledge that I read (and received, if requested) a copy of Care in Motion, Physical Therapy's Notice of Privacy Practice.
If an insurance check is sent to me, I agree to deliver the check to Care in Motion, Physical Therapy, LLC. If check is made out to me, I agree to endorse check and forward it to Care in Motion, Physical Therapy, LLC. In either case, a copy of the Explanation of Benefits should accompany the check. Please endorse check "made payable to "Care in Motion, Physical Therapy, LLC." with your signature.

Please note: We request your cooperation in keeping your appointment to help us stay on schedule. We are not reimbursed for missed appointments. A cancellation fee of $30 will be applied to your bill for a cancellation made with less than 24 hours' notice.

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Patient's Signature: __________________________________ Date: _____________
Persons or clinicians I authorize to receive my personal and/or medical information:

Name_________________________Relationship_________________________

Name_________________________Relationship_________________________

Name_________________________Relationship_________________________

Permission to receive messages via Text or Email

I hereby give Care in Motion, Physical Therapy, LLC and any members associated with Care in Motion, Physical Therapy, LLC permission to send my personal and/or medical information via text or email from any number or email address associated with Care in Motion, Physical Therapy, LLC
Please use following for such communication:

Phone Number_________________________________initial_____

Cell Phone Number_____________________________initial_____

Email address_________________________________ initial_____

Patient Signature_____________________________________Date______________