

Please read carefully and print clearly. Thank you!

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
Email: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about InsideOut Body Therapies?  
 Internet  Friend  Physician  Other \_\_\_\_\_  
The studio sends a newsletter every **other** month with updates, specials, and new offerings.  
\* **Would you like to receive InsideOut's newsletter?**  YES  NO  
**How do you prefer to receive appointment reminders?**  Text  Email  Text and Email

**Physician Referral Information:**

Referring Physician's Name \_\_\_\_\_ Diagnosis \_\_\_\_\_ Injury Date \_\_\_\_\_  
Name of Medical Facility \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Payment Information:**  Insurance  Self Pay / Cash Pay  
\*Copay / Coinsurance or Self Pay is due day of service.

**Insurance Information:** Please provide your insurance card to the front desk.  
IOBT currently files for BCBS Insurance Policies only. (\* Blue Local is out-of-network) Encounter forms can be provided for Cash Pay patients to file with their insurance policy.

Patient's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Policy Name: \_\_\_\_\_  
Subscriber / Member ID #: \_\_\_\_\_  
Group Number: \_\_\_\_\_

\*\*If you are on a spouse's or parent's policy, please provide their name and date of birth. This information is required for filing insurance claims.

**Guarantor / Policy Holder's Full Name:** (please print) \_\_\_\_\_

**Date of Birth of Policy Holder:** \_\_\_\_\_

\*\*Please refer to page 2 for policies and consent to treat.\*\*

**CONSENT TO TREAT**

I, \_\_\_\_\_, consent to treatment as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

**CONSENT TO DISCLOSE**

I, \_\_\_\_\_, authorize InsideOut Body Therapies, LLC practitioners and instructors to share my protected health information as it pertains to the course of my treatment and healthcare.

**LATE CANCELLATIONS AND “NO-SHOW” POLICY**

We honor and respect your time and our service to you is our highest priority. In return, we ask that you also respect our schedule so that we may be available not only to service you, but to also service others.

Late cancellations and “No-Shows” prevent our ability to see other patients needing treatment and results in the practitioner not getting paid for the hour.

InsideOut Body Therapies has a **24-hour cancellation policy** for all scheduled appointments. There is a charge of **\$50**, billed to the patient for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice. **This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.**

**First Late Cancellation / No-show:** Client will receive a phone call informing you that you missed the scheduled appointment. No charge will be applied.

**Second Late Cancellation / No-show:** Client will receive notice of 2<sup>nd</sup> cancellation or no-show and will incur a charge of \$50.00. Payment must be made on or before next scheduled session.

**Repeated late cancels and no-shows (4+)** will result in the client being place on a “Schedule Based on Availability”, meaning client will need to call the day to check availability.

Thank you for your understanding of this policy, as this helps us to serve you and our other clients more promptly and efficiently. **Please Initial** \_\_\_\_\_

**Account Balances: Balances due for incurred fees or Insurance filing / non-reimbursement**

IOBT will file BCBS insurance claims on your behalf. However, if said claim(s) are repeatedly denied due to parameters or restrictions within their insurance policy, the client is responsible to pay the balance due for services rendered. IOBT will notify client with an account statement. *Uncollected balances will be reported to Credit Reporting Agencies.*

**Credit Card Payments:**

Patients have an option to charge balances to a credit card saved on their file. IOBT will notify client with an account statement prior to any charges to their credit card. Per client’s request (either written or verbal), IOBT will charge card on file for the balance due. This agreement shall remain in force unless client requests change in writing. Client will not dispute IOBT’s charges to credit card so long as the amount in question is for services rendered and/or part of studio late cancel and no show policy.

**LAWSUIT CLAIMS:**

Payment IN FULL must be paid at the time of service. IOBT will not bill law firms or any other outside parties for services rendered. IOBT will provide receipts, statements and medical documentation as needed for legal or insurance purposes.

**Please Print full Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_