Back in Motion Physical Therapy P.L.C.
Patient Registration and Authorization Form
Please Print

Today's Date:_____ **Diagnosis:** _____**Date of Birth:**_____
Patient Name: First_____ **Last**_____
Social Security #:_____ **Male**_____ **Female**_____ **Married**___**Single**___**Widowed**___
Home Address: _____
City: _____**State:**_____**Zip Code:**_____
Phone Numbers: Home: _____ **Cell:** _____
Work:_____ **Email Address:**_____
Employer: _____ **Occupation:** _____

Who can we thank for sending you to Back in Motion PT? _____
M.D. _____ **Friend** _____ **Insurance Co.**_____**Internet** _____ **Other**_____
Is this treatment related to an auto accident Yes ___ **No** ____ **If YES, Injury Date**_____
Have you had any physical/occupational/speech therapy this calendar year? Yes No # of visits_____

Referring Physician: _____ **Phone #**_____
Primary Care Physician: _____ **Phone #** _____

Primary Insurance Company:_____
Policy Holder: _____ **Policy Holder Date of Birth:**_____
Relationship: _____**Social Security #**_____ **Policy Holder Employer:** _____

Secondary Insurance Company: _____
Policy Holder: _____**Relationship:** _____
Policy Holder Date of Birth: _____**Social Security #**_____

Tertiary Insurance Company: _____**Policy Holder:**_____
Relationship: _____**Policy Holder Date of Birth:**_____**Social Security #**_____

Workman's Compensation Claim # _____**Injury Date :** _____
Adjuster and Agency_____ **Phone #** _____

Emergency Contact: _____
Phone # _____**Relationship:** _____

The undersigned hereby authorizes the release of any information requested by the insurance co. designated above and authorizes payment by such insurance company of medical benefits to Back in Motion Physical Therapy P.L.C. for services rendered. This does not apply if the patient has paid Back in Motion Physical Therapy directly. **The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by Back in Motion Physical Therapy P.L.C. whether or not such services are covered by insurance benefits. Insurance plan participants are fully responsible for their designated deductibles, copay and coinsurance amounts. These amounts are collected on each day of treatment.** The undersigned agrees to reimburse Back In Motion Physical Therapy P.L.C. for any expenses, including reasonable attorney fees, incurred in connection with the collection of sums due for services performed hereunder.

Patient/Responsible Party Signature: _____ Date: _____

Back In Motion Physical Therapy
Patient Health Questionnaire

Date: _____

Patient Name: _____ Height: _____ Weight: _____ Age: _____

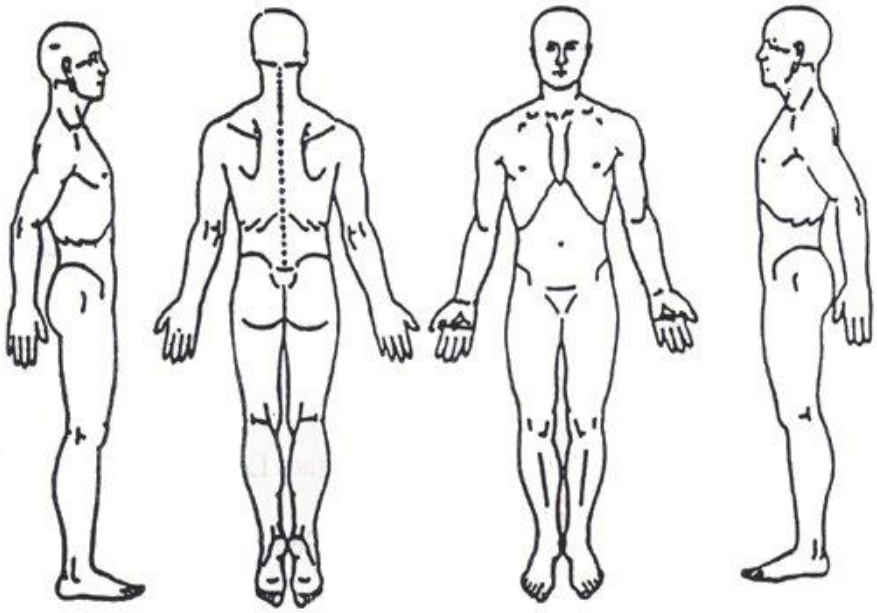
1. Onset of Symptoms/Injury Date_____ Surgery Date (if applicable)_____
2. Describe your symptoms:_____
3. How did your symptoms start or most recently flare-up?_____
   _____
4. During the past week indicate the average intensity of your symptoms on a scale of 0 -10.
   With **0 being NO PAIN** and **10 being UNBEARABLE PAIN: 0 1 2 3 4 5 6 7 8 9 10**

5. During the past week how much has pain interfered with your normal work? (include work outside the house and housework) Please circle:
   Not at all A little bit Moderately Quite a bit Extremely

6. Have your symptoms caused you to stop or limit participation in events such as? please circle**;**
   work church gym recreation other_____
7. How often do you experience your symptoms? Circle: **Constantly Intermittently**

8. What describes the nature of your symptoms? Circle: **Sharp Shooting Stiffness**
   Burning Dull ache Weakness Numb Tingling Off balance

9. How are your symptoms changing? Please Circle **Getting better No Change**
   Getting Worse Fluctuating Unpredictable
10. Have you had similar symptoms in the past? **NO YES If so when_____**
11. Please draw below where you have pain or other symptoms?



Please list your current medications

_____
_____
_____
_____
_____
_____
_____

12. Who have you seen for your current symptoms? Circle: **Primary Dr. Specialist No One**
Chiropractor Acupuncturist Physical Therapist Masseuse Other_____

13. What tests have you recently had completed for your symptoms?
X-Ray Body part_____ Date_____
MRI Body part_____ Date_____
CT Body part_____ Date_____
Other _____ Date_____

14. What is your current work status? Circle: **Full time Part time Student Retired**
Homemaker Other_____ Occupation (if applicable)_____

15. Are any of the following factors contributing to your current condition? Please circle:
sedentary lifestyle fear avoidance fear of falling vision hearing
memory current home environment alcohol use drugs obesity

16. Please identify up to three important activities that you are unable to do or are having difficulty doing as a result of your current injury or problem. Circle the number on the line that best fits your current ability. **0 being UNABLE TO PERFORM ACTIVITY** and **10 being ABLE TO PERFORM ACTIVITY AT THE SAME LEVEL AS BEFORE INJURY OR PROBLEM.**

		UNABLE										ABLE
1.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3.	_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Medical History

Please mark Yes or No for each of the following. Any YES answers please explain.

Cardiovascular System:	**Yes**	**No**	**Explain**
Lightheadedness	___	___	_____
Heart disease	___	___	_____
Pacemaker	___	___	_____
High Blood Pressure	___	___	_____
Chest pains with rest	___	___	_____
Night sweats	___	___	_____
Shortness of breath	___	___	_____
Excessive sweating	___	___	_____
Heartbeat in abdomen when you lie down	___	___	_____
Leg cramps when walking several blocks	___	___	_____
Pulmonary System:			
Difficulty or labored breathing	___	___	_____
Prolonged cough	___	___	_____
Lung/Asthma	___	___	_____
Smoke/tobacco use	___	___	_____

Blood Born Diseases:	**Yes**	**No**	**Explain**
HIV	___	___	_____
West Nile Virus	___	___	_____
Hepatitis A, B or C	___	___	_____
Lyme's Disease	___	___	_____
Gastrointestinal & Urogenital System:			
Diarrhea or constipation	___	___	_____
Abdominal pain	___	___	_____
Pain or difficulty when urinating	___	___	_____
Leak urine w/cough, sneeze or exercise	___	___	_____
Changes in menstruation pattern (female)	___	___	_____
Currently pregnant	___	___	_____
Endocrine System:			
Unexplained weight loss or gain	___	___	_____
Diabetes	___	___	_____
Thyroid problems	___	___	_____
Easy bruising	___	___	_____
Nervous System/Musculoskeletal			
Have you fallen with injury and/or fallen 2 or more times in the past year?	___	___	_____
Dizziness	___	___	_____
Gait or balance disturbances	___	___	_____
Neurological problems/stoke	___	___	_____
Abnormal Numbness, pins, needles	___	___	_____
Muscle weakness	___	___	_____
Headaches	___	___	_____
Changes in vision	___	___	_____
Arthritis /Joint problems	___	___	_____
Night pain	___	___	_____
Trauma	___	___	_____
Morning stiffness	___	___	_____
Prolonged use of corticosteroids	___	___	_____
Integumentary System:			
Changes in skin color or nail integrity	___	___	_____
General:			
Cancer	___	___	_____
Surgeries	___	___	_____
Fever/Chills	___	___	_____
Unusual swelling/edema	___	___	_____
Other medical conditions	___	___	_____

Any additional explanations: _____

_____

Back In Motion Physical Therapy P.L.C.
Policies and Procedures

Please read and initial each paragraph and sign the last page.

We take your health care very seriously and want to provide the highest quality of care possible. Unlike other physical therapy practices, we are proud to offer high quality one-hour individual appointment sessions with a licensed physical therapist. Our unique approach allows exceptional results and a high rate of patient satisfaction.

_____ **(initial)** **Cancellation Policy**:
Please contact us **24 business hours prior to your scheduled appointment** to notify us of any cancellations. **If 24-hour notification is not given**, **you will be charged $50 for the missed appointment**. **This amount will be collected directly from your credit card on file**. To cancel a *Monday* appointment, please call our office by 4:00 p.m. on *Friday*. If over the weekend you need to cancel a Monday appointment please leave a message as soon as possible so we can attempt to fill the appointment first thing Monday morning**. If we fill your appointment you will not be charged**.

_____ **(initial)** **No Show Policy**:
If you fail to show up for a scheduled appointment a $50 no show fee will be charged to you. This amount will be collected directly from your credit card on file.

_____ **(initial)** **Late Policy**:
If you will be late for your scheduled appointment please call and inform us. We will try to accommodate you however your treatment session may be reduced in order to remain on time for the courtesy of the next scheduled patient. If you are more than 30 minutes late we may need to reschedule and this will result in a missed appointment fee of $50. This amount will be collected directly from your credit card on file.

_____ **(initial) We do understand that unforeseen matters of sickness or emergencies occur that you cannot control,** unfortunately we still need to charge for these missed appointments. Thank you for your understanding and cooperation.

_____ **(initial)** **HIPAA**: I have read and understand that I have a right to a copy of Back In Motion Physical Therapy's HIPAA privacy notice. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

_____ **(initial)** **Appointment Reminders:**
We offer automated reminder phone calls, text messages or emails as a courtesy to our patients, however it is ultimately your responsibility to attend your scheduled appointment. Please be sure that the phone number or email you have provided us is correct in order to receive these reminder messages.

I prefer to receive appointment reminders by:

Please circle one: **Phone Call** **Email** **Text Message** **None**

Please list the appropriate phone number or email: _____

_____ **(initial)** **Payment Policy**: **In Network Patients (Excluding Medicare)**
Anticipated patient responsible charges such as: **copays, coinsurance and deductibles will be collected at the time of service**. We require a **credit card to be maintained on file for charging any fees determined to be patient responsibility**. I hereby agree to pay any and all charges that are not covered by my insurance plan, such as if my insurance plan does not pay for any reason, including exceeding maximum benefits, failure to obtain pre-authorization or denial related to medical necessity. You may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk prior to your treatment to avoid the charges being run on the credit card on file.

_____ **(initial)** **Payment Policy: Medicare Patients**
I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, medical supplies, no show and late cancel fees. **We require a credit card to be maintained on file** for charging any fees determined to be patient responsibility. You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.

_____ **(initial)** **Payment Policy**: **Out of Network Patients**
Please come prepared to make a payment at each visit. **You will receive an itemized bill at the time of service**. We accept cash, check and major credit cards. **We require a credit card to be maintained on file** for charging visit fees, medical supplies, no show and late cancel fees. You may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk prior to your treatment to avoid the charges being run on the credit card on file.

_____ **(initial)** **Authorizations**:
Some insurance companies require authorization or a referral for physical therapy. Although we will assist you in this matter, ultimately this is your responsibility to understand your insurance benefits. If your insurance does not authorize your visits in a timely manner we may need to cancel your appointments until authorization is obtained.

_____ **(initial)** **Return Check Fee**:
If checks are returned from the bank there will be a $20 returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

_____ **(initial)** I understand that I am solely responsible for the balance due on my account and agree to pay any unpaid balance due. **As a courtesy, benefits are verified but are NOT A GUARANTEE of payment/coverage**. All claims are subject to review by your insurance company. If your account balance matures to over 120 days and remains unpaid, your account will be sent to collections and we will no longer be able to assist you with the account. Any accounts in default and sent to collections could be assessed attorney fees, court costs and interest of 1% per month. We hope this course of action is unnecessary however we are required to notify you of this information.

We appreciate your patronage and if you have any questions or concerns please ask. I have read and fully understand the above policies and procedures of Back In Motion Physical Therapy P.L.C. and agree to these terms.

Signature of Patient/ Responsible Party: _____Date:_____