Back in Motion Physical Therapy P.L.C
Golf Rehabilitation-Golf Fit Golf Strong Training Program
Registration and Authorization Form

Today's Date:_____

Date of Birth:_____

Name:First_____Last_____

Home Address:_____

City: _____State:_____Zip Code:_____

Phone Numbers: Home: _____ Cell: _____

Work: _____Email Address:_____

Who can we thank for sending you to Back in Motion PT? _____

M.D. _____ Friend _____ Coach _____Internet _____ Other_____

Primary Care Physician: _____ Phone # _____

Emergency Contact: _____

Phone # _____Relationship: _____

The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by Back in Motion Physical Therapy P.L.C. These amounts are collected on each day of service. 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 P.L.C
Golf Rehabilitation-Golf Fit Golf Strong Training Program Policies and Procedures
Please read and initial each paragraph and sign the last page

We take your fitness and golf rehabilitation and performance goals very seriously. We are proud to offer exemplary one-hour golf rehabilitation and training sessions with doctorate degree physical therapists who are former NCAA athletes, certified by Titleist Performance Institute, who have worked with professional and collegiate athletes. Our unique approach allows exceptional results and a high rate of participant satisfaction.

_____ **(initial)** As a reminder health insurance companies do not reimburse for fitness and golf performance services but rather only for those patients suffering from functional or painful impairments. Hence these training sessions need to be paid for in full by the client prior to each session.

_____ **(initial)** **Cancellation Policy:**
We are committed to providing all of our clients one-on-one or small group reserved one-hour appointments with our Doctorate of PT Titleist Golf Certified specialists. If you are unable to attend your reserved scheduled session, please call our office at least **48 business hours prior to your scheduled appointment** to notify us of any changes or cancellations. *Business hours are from 7am on Monday through 2pm on Friday, excluding holiday closures.* **If a 48-hour notification is not given, you will be charged $50 for each member missing the training session.This amount will be collected directly from your credit card on file**. To cancel a *Monday* or *Tuesday* appointment, please call our office by 2:00 pm on *Friday*. If over the weekend you need to cancel a Monday or Tuesday appointment, please leave a message as soon as possible.

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

_____ **(Initial)** Please keep in mind that if a member of a small group cancels their session with more than 48hrs notification, the entire group session may need to be rescheduled for another day.

_____ **(initial)** **Late Policy:** If you think you will be late for your scheduled session, please call and inform us. We will try to accommodate you, however your training session time may be reduced in order to remain on time for the courtesy of the next scheduled patient or client. If you are late or need to leave early you will still be charged for your full hour training session.

_____ **(initial)** **Same Day Scheduling:** If you no show and/or late cancel more than twice, your future appointments will be canceled and you will be placed on **SAME DAY SCHEDULING**. This means you may contact us in the morning of a day you are available to ask for a same day appointment.

_____ **(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 sessions. Thank you for your understanding and cooperation.

_____ **(initial) <u>Appointment Reminders</u>**: As a courtesy to our clients, we offer automated reminder phone calls, text messages or emails, **however it is ultimately your responsibility to attend your scheduled session**. 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 <u>ONE</u>: Phone Call Email Text Message None

Please list the appropriate phone number or email: _____

_____ **(initial) <u>Return Check Fee</u>**: If checks are returned from the bank there will be a $35 returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

_____ **(initial) <u>Payment Policy</u>: Our fees are $130.00 for individual training sessions; $65.00 per person for a group of (2) participants; and $50.00 per person for a group of (3) participants.** Personalized and small group training session fees will be collected at each visit. We require a credit card to be maintained on file for charging training fees, supplies, no show and late cancel fees. You may still pay for charges with cash or check by presenting these at the front desk prior to your session to avoid the charges being run on the credit card on file.

_____ **(initial) <u>HIPAA</u>**: I have read and understand I have rights to a copy of Back in Motion Physical Therapy's HIPAA privacy notice. This notice is available upon request and on our website at www.BackinMotionPT.com. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

_____ **(initial)** I understand that I am solely responsible for the balance due on my account. 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. Thank you for trusting us with your specialized golf rehabilitation and training needs. I have read and fully understand the above policies and procedures of Back in Motion Physical Therapy PLC. and agree to these terms.

Signature of Patient/Responsible Party: _____ Date: _____

Back in Motion Physical Therapy P.L.C
Golf Rehabilitation-Golf Fit Golf Strong Training Program
Health Questionnaire

Date: _____

Patient Name: _____Height: _____ Weight: _____ Age: _____

1. Do you have any pain, recent injuries or surgeries: Yes or No? If YES, answer all remaining questions, however, if NO, skip to question #12 and answer the remaining questions.

Onset of Symptoms/Injury Date:_____Surgery Date (if applicable):_____

2. Describe your symptoms and current condition:_____

_____

3. Did you see a doctor or other medical provider for your condition? Yes or No

Did they clear you to participate in sports or physical activity? Yes or No

If yes, name of doctor or medical practitioner who cleared you? _____

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

6. Have your symptoms caused you to stop or limit participation in events such as?

please circle: School Athletics 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. What tests have you recently completed for your symptoms/injury?

X-Ray body part:_____ Date:_____

MRI Body part: _____ Date:_____

CT Scan Body Part: _____ Date:_____

Other: _____ Date:_____

12. Please identify your top 3 goals that you want to achieve through our Golf Rehabilitation - Golf Fit Golf Strong training program. Be as general or as specific as you wish.

1. _____

2. _____

3. _____

13. What particular part of your athleticism, mobility or fitness appears to be holding you back from furthering your potential to reach your goal? _____

14. How much personal time are you willing to dedicate to your golf fit-golf strong program?
_____ hours/day _____days/week

15. Medical History

*** Everyone needs to complete this section**

Please list your current medications (if any): _____

_____ _____ _____ _____

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	___	___	_____
Leg cramps when walking 5 min	___	___	_____
Pulmonary System:			
Difficulty or labored breathing	___	___	_____
Prolonged cough	___	___	_____
Lung/Asthma	___	___	_____
Smoke/tobacco use	___	___	_____
Blood Born Diseases:			
HIV	___	___	_____
West Nile Virus	___	___	_____
Hepatitis A, B or C	___	___	_____
Lyme Disease	___	___	_____

Gastrointestinal & Urogenital System:	**Yes**	**No**	**Explain**
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: _____

_____