

**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 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:**

We are committed to providing all our patients one-on-one, one-hour appointments. When a patient cancels without giving enough notice, they prevent another patient from being seen. All appointments require at least **48 hours advance notice on a business day** for any **changes or cancellations**. *Business hours are from 7:00am on Monday through 2:00pm on Friday, excluding holiday closures.* **If 48-hour notification is not given, you will be charged \$60 for the missed appointment. This amount needs to be paid at the time of your cancellation or before your next visit and will be collected directly from your credit card on file.** To cancel a Monday or Tuesday appointment, please call our office by 2:00 p.m. on Friday. If over the weekend you need to cancel a Monday appointment, please leave a message as soon as possible. **Text and email cancellations are not valid. Please call the office for ALL appointment cancellations.**

\_\_\_\_\_ (initial) **No Show Policy:** If you fail to show up for a scheduled appointment, a **\$60 no show fee will be charged to your credit card on file.**

\_\_\_\_\_ (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. We will be happy to place you with any therapist who may have an opening.

\_\_\_\_\_ (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 time may be reduced in order to remain on time for the courtesy of the next scheduled patient. For patients whose insurance we are billing, **a delay in your arrival or an early departure from your scheduled one-hour session will incur a \$20 charge for every 10 minutes you are absent. If you self pay and are late or need to leave early, you will still be charged for your full hour treatment session.**

\_\_\_\_\_ (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** in order to continue providing one-hour individual appointment sessions. Thank you for your understanding and cooperation.

\_\_\_\_\_ (initial) **Appointment Reminders:** 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 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) **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) **Payment Policy: Insurance Billing**

**Copays, coinsurances, and deductibles will be collected at each visit. We require a credit card to be maintained on file for charging any fees determined to be patient responsibility. Your credit card will continue to be charged as your insurance processes, which may occur even after you have been discharged.** I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, dry needling, medical supplies, no show and late cancel fees, or 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. If you have a **secondary or supplemental insurance**, you are responsible for any remaining primary insurance patient liability amounts after your secondary pays. 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: Self Pay Patients**

**Our self pay fee is \$177 for the Evaluation (first) visit and \$150 for each follow up visit.** Please come prepared to make a payment at each visit. **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. At the end of each treatment session, you will receive an itemized bill that you can submit to your insurance company. Although we are here to assist you with understanding your insurance coverage, **any reimbursement from an insurance company is the responsibility of the patient.**

\_\_\_\_\_ (initial) **Authorizations:** Some insurance companies require authorization or a referral for physical therapy. Although we will assist you in this matter, ultimately it 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) **HIPAA:** I have read and understand that 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](http://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. **As a courtesy, benefits are verified but are NOT A GUARANTEE of payment/coverage.** All claims are subject to review by your insurance company. I agree to pay any unpaid balance due. 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 thank you for trusting us with your physical therapy needs. 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: \_\_\_\_\_

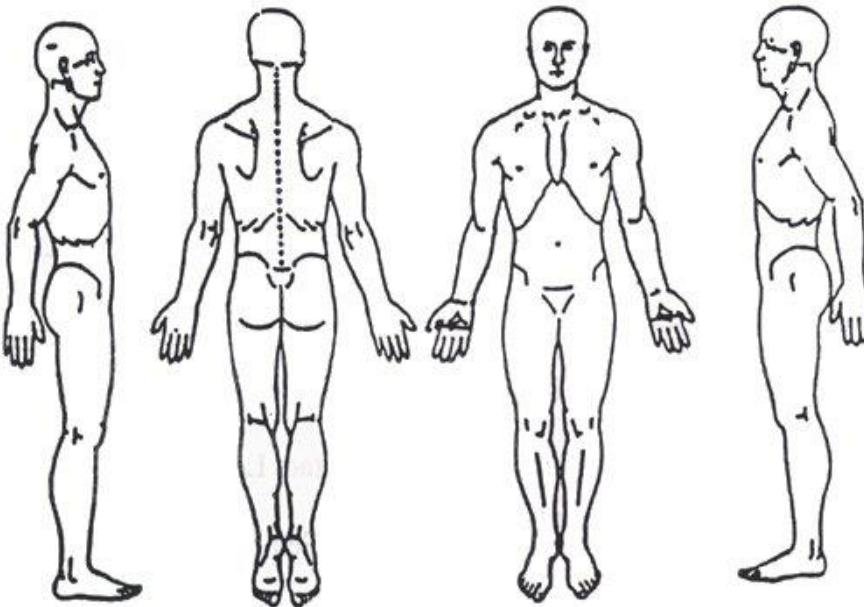
# Back In Motion Physical Therapy

## 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**

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Patient Last Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

## 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:

	Yes	No	Explain
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/stroke

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_