

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:**

Back In Motion PT is committed to providing all of our patients one-on-one, 1-hour appointments. When a patient cancels without giving enough notice, they prevent another patient from being seen. **Please contact us 24 hours prior to your scheduled appointment to notify us of any changes or 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* to avoid a late charge.** 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.** These missed/unfilled appointments will be charged a \$50 fee. Thank you for your understanding and cooperation.

_____ (initial) **Reminder Calls:**

We offer automated reminder messages as a courtesy to our patients, **however it is ultimately your responsibility to attend your scheduled appointments.** Please be sure that the phone number or email you have provided is correct in order to receive these reminder messages.

I prefer to receive appointment reminders by:

CIRCLE ONE: Phone Call Email Text Message None

Please list the appropriate phone number or email: _____

Print Patient Last Name: _____ Date: _____

_____ (initial) **Payment Policy:**

Copays, coinsurance, and deductibles will be collected at each visit. Back In Motion PT requests payment of anticipated patient responsibility 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 deductible, coinsurance, copayments, 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. 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 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) **Return Check Fee:**

If checks are returned from the bank there will be a returned check fee assessed to your account. **This amount will be collected directly from your credit card on file.**

_____ (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) 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 the 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 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: _____

Back In Motion Physical Therapy

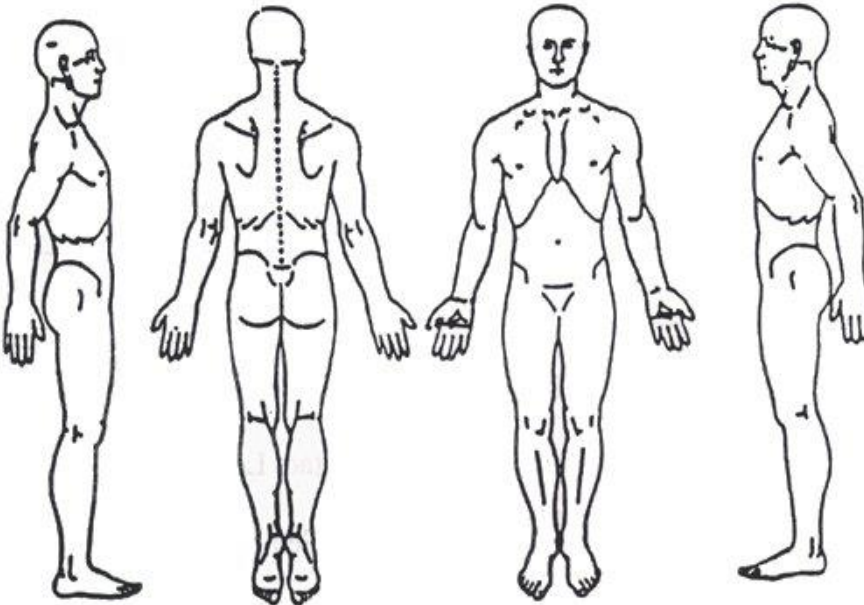
Patient Health Questionnaire

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

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:

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	_____	_____	_____
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General:

Cancer	_____	_____	_____
Surgeries	_____	_____	_____
Fever/Chills	_____	_____	_____
Unusual swelling/edema	_____	_____	_____
Other medical conditions	_____	_____	_____

Any additional explanations: _____