

**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 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. 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 **\$50.00 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 because of time restraints of the next scheduled patient. We try to keep on schedule for the courtesy of all our patients. **If you are more than 30 minutes late we may need to reschedule and this will result in a missed appointment fee of \$50.00. This will be collected at your next scheduled appointment.**

\_\_\_\_\_ **(initial)**    **Late Policy: Out of Network/ Self Pay only**

If you think 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. **If you are late 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.** These missed/unfilled appointments will be charged a \$50 fee. Thank you for your understanding and cooperation of this matter.

\_\_\_\_\_ **(initial)**    **Reminder Calls:**

We offer automated reminder calls as a courtesy to our patients, **however ultimately it is 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.** We request 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 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 returned check fee assessed to your account. You will need to pay this amount at your next visit.

\_\_\_\_ (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, you 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 cost and interest of 1% a 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: \_\_\_\_\_

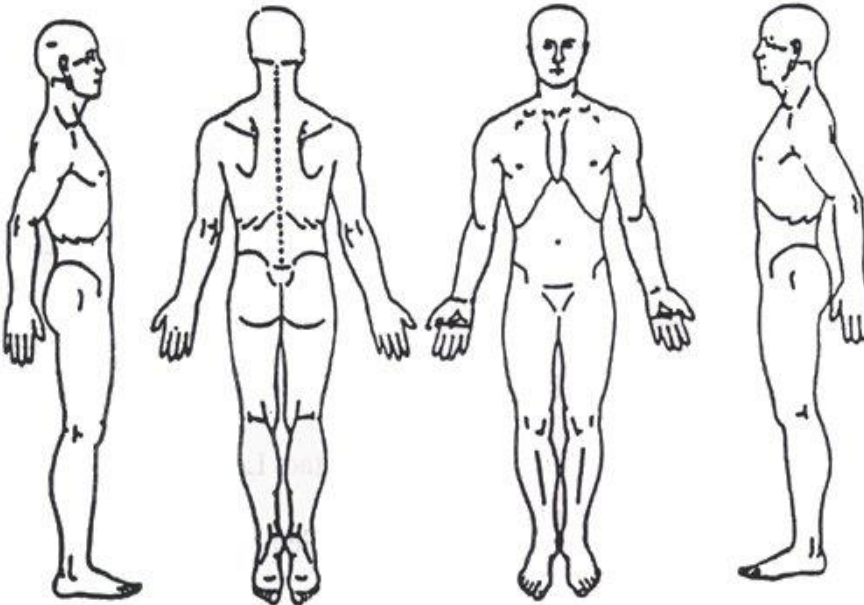
# Back In Motion Physical Therapy

## 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**

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

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

pg.2

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: \_\_\_\_\_