BACK IN MOTION
Physical Therapy, LLC

PATIENT DEMOGRAPHICS Today's Date:_____

Please Print

Patient Name:_____Sex: Male Female
Last First Middle

Birthday: _____ Social Security #:_____Referring Doctor:_____

Marital Status: _____ Next Dr. Appoint.:_____

Home Phone: (___) _____Wk. Ph:_____Cell Ph:_____

Mailing Address: _____ e-mail_____

_____
City state zip

Primary Insurance:_____ Secondary Insurance;_____

Insurance Policy Holder's Name:_____ Date of birth_____

Responsible Party's Mailing Address: (if they do not live with patient)

_____
Street City State Zip Code

Notify in Case of Emergency:_____Phone:_____

AUTHORIZATION FOR TREATMENT
I hereby voluntarily consent to medical care for the above named patient encompassing evaluation and treatment by the physical therapist, his/her assistants, or designees in his /her judgment. I acknowledge that no guarantees have been made as to the results of evaluation or treatment.

_____
Signature Date

ASSIGNMENT OF BENEFITS
I hereby assign all rights, title, and interest in the benefits payable to me by any insurance policy(ies) or benefits plan under which I am covered for services rendered by the physical therapist. I understand that I am responsible for all charges not covered by this assignment and hereby promise to pay any remaining balance.

_____
Signature Date

AUTHORIZATION OF RELEASE OF INFORMATION
I authorize BACK IN MOTION PHYSICAL THERAPY, LLC to release to the insurance carrier, Social Security Administration, third party administrators, or any party that may be liable for all or part of medical charges information as may be necessary for the purpose of enabling the determination of benefits available to the patient for the services rendered during this period of care.

_____
Signature Date

FOR OFFICE USE ONLY----------

BACK IN MOTION PHYSICAL THERAPY, L.L.C.

PATIENT INFORMATION

PLEASE READ AND SIGN

We take your health care very seriously and want to provide the highest quality of care possible.

Parking: There is parallel parking in front of the office. There is also parking behind the office, off of the alley. A concrete walk leads to the front entrance.

Missed appointments can slow your progress and recovery, but if you need to cancel an appointment, kindly notify our office.

Late and Cancellations: If you think you will be late for an appointment, please call and inform us. We will try to accommodate you: however, your treatment session may need to be reduced because of time restraints of the next scheduled patient. We try to keep on schedule for the courtesy of our patients. If you are 20 -30 minutes late, we may need to reschedule.

Payment: If your insurance requires a co-pay, it will be due at the time of service. Payments can be made by cash, check or credit card. Although we participate with some insurance companies, there are others in which we do not participate with. If we are not providers for your company, payment is expected at time of service. Please understand, we are not liable if your insurance does not cover your visits or reduces the amount paid because authorization was not obtained. Some insurance companies require prior authorization or a referral for physical therapy. Although we assist you in this matter, ultimately this is your responsibility to make sure that it is obtained.

I understand that I am solely responsible for the balance due on my account. I agree to pay the unpaid balance due. In the event that it's necessary, a payment plan can be discussed. (This policy will not apply to Worker's Compensation patients.)

HIPAA: I hereby attest that I have seen Back In Motion Physical Therapy's Notice of Privacy Practices. I understand that a copy of this form is available to me. I have the right to request restrictions on the use of my information.

I have read and fully understand the above policies and procedures of Back In Motion Physical Therapy, LLC and agree to these terms.

Signature_____ **Date**_____

BACK IN MOTION
Physical Therapy, LLC

Patient Name:_____

1. Injury date/ onset of Symptoms: __/__/__ Surgery Date: __/__/__

2. Describe your symptoms:_____

3. Injury related to: __automobile, __Worker's Comp injury, __other injury or illness

4. How did your symptoms start or most recently flare-up? _____

5. How often do you experience symptoms? __constantly __intermittently

6. What best describes the nature of your symptoms?

__sharp __dull ache __numb __shooting __burning __tingling __stiffness __weakness __off balance

7. How are your symptoms changing? __getting better __not changing __getting worse

8. Who have you seen for your symptoms? __primary care doctor __Specialist __physical therapist

__Masseuse __Chiropractor __no one __other

9. What tests have you recently had for your symptoms, and when were they performed?

__Xray body part:_____ date:__/__/__ ___CT Scan body part:_____ __/__/__

__MRI body part:_____ date:__/__/__ ___ other body part: _____ __/__/__

10. Have you had similar symptoms in the past? _____

11. What is your current work status?

__student __homemaker ___ retired __full-time __part-time __off work

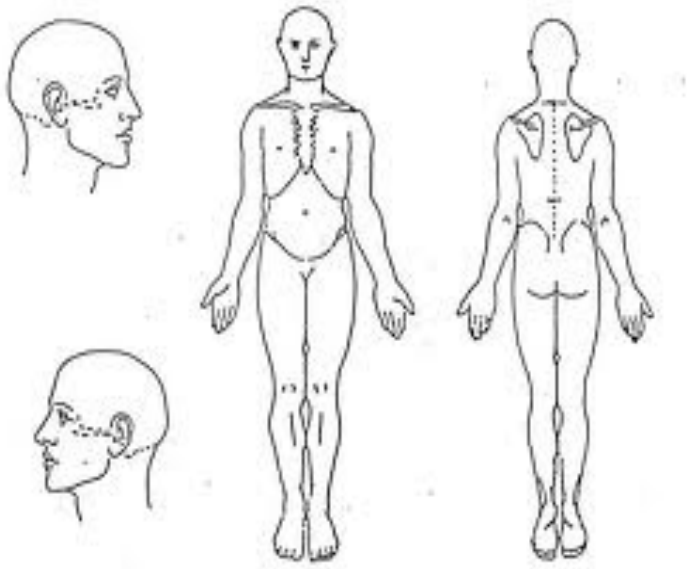
12. Occupation_____

13. If Worker's Comp, place of employment at time of injury:_____

Rate your pain 1……..2……..3……..4……..5……..6……..7……..8……..9……..10

slight moderate extreme

Please indicate where your pain is located at the present time by marking the area.



Please circle Y or N for each of the following:

Y / N Heart Disease

Y / N Lung / Breathing Problems

Y / N Cancer

Y / N Neurological Problems

Y / N Bone / Joint Problems

Y / N Diabetes

Y / N Surgeries

Y / N Pacemaker / Defibrillator

Y / N Currently Pregnant

Y / N Arthritis

Y / N Asthma

Y/N Circulatory Problems

Y/N Thyroid Problems

Y/N High Blood Pressure

Y/N Stroke

Y/N Numbness

Y/N Balance Problems/Recent Falls

Y/N Kidney Disease

Y/N Depression

Y/N Hepatitis

Y/N Osteoporosis

Have you had Physical Therapy, for any reason, at any time, at any clinic, this calendar year?

Yes or N

Please list any prescription medications that you are currently taking. (If you already have a list, we will be happy to make a copy for you.)

NON-COVERED SUPPLIES

Thank you for choosing BACK IN MOTION Physical Therapy for your rehabilitation. It is our goal to provide high quality care to every patient. Occasionally for optimal treatment, extra supplies are needed which are *not covered* by insurance. Iontophoresis, Intramuscular Therapy (also referred to as Dry Needling), and Kinesiotaping require costly supplies that are *not covered* by insurance . A minimal fee per treatment is charged to the patient.

Iontophoresis is $15 per treatment

Intramuscular Therapy is $5 per treatment

Kinesiotaping is $5 per treatment

By marking yes, if any of these procedures are necessary for your treatment, you are accepting responsibility for the above supply charges.

YES_____

NO_____

Name_____ Date_____