DEMOGRAPHICS RECORDS

PRO-MOTION Physical Therapy

PATIENT INFORMATION

Injury/Diagnosis: _____

Referral Source: _____

First Name: _____

Middle Initial: _____

Last Name: _____

Gender: ☐ *Male* ☐ *Female*

Date of Birth: ____/____/____

SSN or ID #: _____

Marital Status: ☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Minor (under 18)*

Previous Patient? ☐ *Yes* ☐ *No*

If YES, what year: _____

Address: _____

City: _____

State: _____

Zip code: _____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Email Address: _____ @ _____

Employer: _____

Occupation: _____

Emergency Contact: _____

Relationship to Patient: _____

Cell Phone: ( ) _____

APPOINTMENT REMINDERS:

☐ **Email** ☐ **Voice Call** ☐ **Text** ☐ **No Reminder**

INSURANCE INFORMATION

Insurance Company: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Employer: _____

Motor Vehicle Accident? ☐ *Yes* ☐ *No*

Work Related Accident? ☐ *Yes* ☐ *No*

Date of Injury: _____

Claim Number: _____

Claim Manager/Adjustor: _____

Phone Number: _____

PATIENT INTAKE QUESTIONNAIRE

PRO-MOTION Physical Therapy

Patient Name: _____ Height: _____ Weight: _____

ABOUT YOUR CURRENT COMPLAINT:

1. What is the issue or reason for your visit today? _____

2. When did this begin? Date: _____ Has it recently worsened? Yes No Date: _____

3. Please let us know about your current situation...

   I can't or am unable to... _____

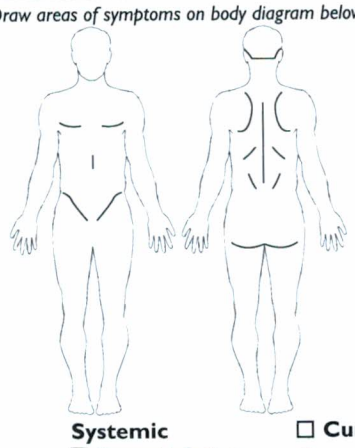
   I am hesitant or afraid to... _____

   It hurts when I... _____

4. Please rate your pain. *(on the scale of 0-10 place a check mark)*

	no pain				*moderate pain*						*severe pain*
At your worst.	0	1	2	3	4	5	6	7	8	9	10
Currently.	0	1	2	3	4	5	6	7	8	9	10
At your best.	0	1	2	3	4	5	6	7	8	9	10

Draw areas of symptoms on body diagram below.



ABOUT YOUR GENERAL HEALTH

5. Rate your general health status. *(please circle one)*

   Good **Fair** **Poor**

6. Please check all medical conditions you have or have had.

Behavioral
- ☐ Anxiety
- ☐ Depression
- ☐ Tobacco Use

Cardiovascular
- ☐ Cardiovascular disease
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ High Cholesterol

Gastrointestinal
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Gallbladder Problems

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Fracture or suspected fracture
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Rhematoid Arthritis
- ☐ Gout
- ☐ Osteoporosis

Pulmonary
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD

Neurological
- ☐ Alzheimer's
- ☐ Cauda equina syndrome
- ☐ Cerebral vascular accident
- ☐ Huntington's
- ☐ Parkinson's
- ☐ Traumatic brain injury
- ☐ Dizzy Spells
- ☐ Multiple Sclerosis
- ☐ Seizures

Urogenital
- ☐ Incontinence

Systemic
- ☐ Current infection
- ☐ Diabetes Mellitus
  - ☐ Type I
  - ☐ Type II
- ☐ History of cancer
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Obesity
- ☐ Autoimmune Disease

  type: _____
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis

- ☐ **Currently pregnant**
- ☐ **None**
- ☐ **Other** *(please specify)*

  _____

  _____

7. Please list any previous surgeries:

   (type and date) _____

8. What goals can we help you achieve?

   _____

   _____

   _____

CANCELLATION AND NO SHOW POLICY

PRO-MOTION Physical Therapy

At Pro-Motion Physical Therapy, we prioritize your progress and well-being through personalized care. To ensure efficient scheduling in the maintenance of a high quality of service for all of our clients, we kindly request your cooperation with our attendance policy

Attendance Expectations:

Your timely attendance at scheduled appointments is crucial for optimal progress in your treatment plan. We believe in the value of consistent attendance to facilitate your recovery and enhance treatment outcomes. Excessive cancellations may necessitate a discussion with your provider, and persistent issues may lead to discontinuation of care.

Respecting scheduled appointments:

Think of your scheduled appointments as reservations at a restaurant. Each visit is reserved specifically for you. Though we understand emergencies can occur, last-minute cancellations and no-shows hinder our ability to serve you effectively and may impact the scheduling needs of other clients.

Cancellations and rescheduling

To maintain a smooth flow of care, we request a minimum 24–hour notice for cancellations or rescheduling. Late cancellations (less than 24 hours) and no-shows not only affect your care but also limit our ability to accommodate other patients. Cancellation\no-show fees may be waived if you reschedule the missed appointment in the same week.

FEES:

Late cancellation: First event: $75.00. Additional events: $100.00

No-shows: $100.00

_____ _____

SIGNATURE OF UNDERSTANDING **DATE**

PATIENT INSURANCE AUTHORIZATIONS

PRO-MOTION
Physical Therapy

In network insurance plans:

Patients are required to provide accurate health insurance information at the initial visit. We will verify insurance coverages, however; it is the patient's responsibility to know their insurance benefits and policy requirements. Verification of insurance coverage does not guarantee payment for treatment rendered, and the patient is ultimately responsible for payment of balances due on their account. It is the patient's responsibility to notify Pro-Motion Physical Therapy of any changes in health insurance coverage during the course of treatment. Pro-Motion Physical Therapy will bill any secondary insurance for you, however; coinsurance may still apply.

Medicare patients: Please note that Medicare has a yearly deductible and a patient responsibility of 20%. Pro-motion physical therapy will gladly bill any secondary insurance you may have for the 20% that Medicare does not cover.

Co-pay and Deductibles:

The patient is responsible for any co–payments at the time that services are rendered. Patient deductibles, co–insurances and non-covered services must be paid within 30 days of receipt of a billing statement from our office. A fee will be charged for all statements 60 days past due.

Workers compensation\no-fault:

Pro-Motion Physical Therapy will attempt to pre-authorize any treatment through your Workers Compensation\No-Fault carrier. In the event that a Workers Compensation\No-Fault case is determined to be closed, or that benefits are denied, the patient will be fully responsible for services rendered.

Assignment of insurance benefits:

By signing this, you hereby authorize your insurance company to make payments to Pro-Motion Physical Therapy, for services rendered to you or your insured dependent. Should any payment be sent directly to you from your health insurance carrier for services rendered at Pro-Motion Physical Therapy the patient shall remit payment/s to Pro-Motion Physical Therapy.

Self pay patients:

If the patient does not have insurance coverage, he\she is responsible for full payments at the time that services are rendered. Please ask about self- pay pricing or payment agreements.

Accepted payments:

Pro-Motion Physical Therapy accepts Cash, checks, and major credit cards for payment. We reserve the right to charge a $30 returned check for any check/s sent back to us from our bank that is not paid.

By under signing, you acknowledge that you have read and understood Pro-Motion Physical Therapy's payment policy form and except financial responsibility for all services rendered during your course of treatment.

_____	_____	_____
PATIENT NAME	**GUARDIAN SIGNATURE FOR DEPENDENT**	**DATE**

PATIENT AUTHORIZATIONS

PRO-MOTION
Physical Therapy

AUTHORIZATION FOR TREATMENT

I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatments to be provided in this healthcare facility. I authorize Pro-Motion Phyiscal Therapy to provide such treatment.

INITIALS _____

PAYMENT AUTHORIZATION

I request that payment be made on my behalf to Pro-Motion Physical Therapy for services furnished to me by Pro-Motion Physical Therapy. I authorize Pro-Motion Physical Therapy to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaide agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts.

MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT OF PHYSICAL THERAPY SERVICES RENDERED.

INITIALS _____

RECORD RELEASE

I hereby authorize Pro-Motion Physical Therapy to release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, or other healthcare agencies, professionals, or persons who may provide health-care services deemed necessary for continuing my medical care.

INITIALS _____

Please also release medical information regarding my physical therapy care to the following individual(s) (i.e., family members, coaches, trainers, etc.). It is not necessary to list physicians or insurance companies here.

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____

HIPAA PRIVACY POLICY

I have been provided a copy of the HIPAA Privacy Policy for review and know that if I would like a copy of it to keep, I have requested one.

INITIALS _____

CANCEL/NO SHOW POLICY

I have read and understand Pro-Motion Physical Therapy's Cancellation and No Show Policy and know that if I would like a copy of it to keep, I have requested one.

INITIALS _____

As part of working with my insurance carrier, I recognize that Pro-Motion Physical Therapy may be provided with information about my insurance coverage and that on occasion Pro-Motion Physical Therapy may share some of this information with me. However, I understand and acknowledge that Pro-Motion Physical Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan documents and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

PATIENT PRINTED NAME: _____ **DATE:** _____

PATIENT/REPRESENTATIVE/
PARENT/LEGAL GUARDIAN SIGNATURE: _____

IF SIGNED BY PATIENT REPRESENTATIVE OR PARENT/LEGAL GUARDIAN, INDICATE RELATIONSHIP TO PATIENT: _____