



Pro Motion Physical Therapy Patient Registration Form

Patient Information										
Patient Name (first, middle initial, last)							Prefers to be Called			
Date of Birth	Age	M/F	Is patient a minor?		If so, name of Primary Parent/Guardian Contact					
Please list your phone numbers and select phone type in the order you would like to be called:										
1. _____			2. _____			3. _____				
home work cell			home work cell			home work cell				
Select the locations where we can leave you messages that may contain health information: home work cell email					Email address					
Home Address				City			State		Zip Code	
Occupation			Employer							
Emergency Contact Name			Relationship			Phone Number				
Person Responsible for Bill			Relationship to Patient		Address (if different)					
How did you hear about us?					Is your injury related to an auto accident? Yes No					
					Is your injury related to an accident at work? Yes No					
Referral Information										
Do you have a prescription? Yes No		Referring Doctor			Have you seen a doctor at any time for this injury/pain?					
Is there anyone other than your referring physician to whom you would like us to fax your evaluation?										
Primary Insurance Information										
Insurance Company Name			Policy Number				Group Number			
Subscriber's Name (if different than self)			Relationship to Patient		Birthdate					
Secondary Insurance (if applicable)										
Insurance Company Name			Policy Number				Group Number			
Subscriber's Name (if different than self)			Relationship to Patient		Birthdate					

I consent to treatment necessary for the care of the above named client. If patient is under 18 years of age and a parent is not able to attend physical therapy sessions, the parent's signature for authorization allows Pro Motion to commence physical therapy treatments with the patient.

Patient Signature

Date

(If patient is a minor, parent or guardian's signature required)



Pro Motion Physical Therapy

Medical History Intake Form

Patient Name (first, middle initial, last)	Date
Current Condition	
Briefly Describe Your Problem (including where you are experiencing pain)	Date of Onset

Did the pain/problem begin:

gradually suddenly

If this episode began suddenly, what action was involved?

Have you had prior episodes of this pain/problem? Yes No If yes, how many episodes have you had? _____

When did the first episode begin? _____ Is this episode worse than the previous episode? Yes No

List activities that you can NOT do because of your current problem:

Please check the activities that affect the pain/problem:

	No Change	Better	Worse		No Change	Better	Worse
Standing				Squatting			
Sitting				Kneeling			
Walking				Bending Backward			
Lifting				Bending Forward			
Pushing/Pulling				Typing/Writing			
Overhead Reaching				Driving			
Lying on Stomach				Coughing			
Lying on Back				Sneezing			

Which special tests have been performed for your current problem?

	Date	Area of Body/Brief Description of Results
X-Rays	_____	_____
Bone Scan	_____	_____
MRI	_____	_____
CAT Scan	_____	_____
Myelogram	_____	_____
EMG/NCS	_____	_____
Epidural Steroid Injection	_____	_____
Nerve Root Block	_____	_____
Facet Joint Injection	_____	_____
Other	_____	_____

Have you had surgery for this problem?

Yes

No

If yes, please answer the following:

Surgery Type

Date

Since the surgery do you feel :

Better Worse Same

Describe the change:

Current Condition *Continued*

Please select the number that best represents your *average* pain (0= no pain, 10=worst pain):

What is the least? 0 1 2 3 4 5 6 7 8 9 10

What is the worst? 0 1 2 3 4 5 6 7 8 9 10

What is it today? 0 1 2 3 4 5 6 7 8 9 10

Goals for Physical Therapy: Please list your goals for physical therapy (ex. To return to playing tennis, to get dressed without pain etc.)

Medical History

Medical History (please check all that apply to you)

- | | | |
|---------------------|---------------------|--|
| Arthritis | Cancer | Recurrent muscle joint pain problems |
| Osteoporosis | High Blood Pressure | Infectious disease (HIV, Hepatitis, etc.) |
| Circulation Disease | Breathing Problems | Currently pregnant or attempting pregnancy |
| Diabetes | Thyroid Condition | Other _____ |
| Heart Disease | Allergies | |

Current Medications: _____

Therapy History:

If you have had physical therapy in the past (for this or another injury) please list where, when and for how long you attended:

Please check the types of treatment you have received (at any time) and indicate how it affected your pain/problem:

- | | No Change | Better | Worse | | No Change | Better | Worse |
|------------------------|-----------|--------|-------|--------------------------|-----------|--------|-------|
| Hot Packs | | | | Chiropractic/Adjustments | | | |
| Ice/Cold Treatments | | | | Acupuncture | | | |
| Ultrasound | | | | Bracing/Splinting | | | |
| Massage | | | | Strengthening Exercises | | | |
| Myofascial Release | | | | Flexibility Exercises | | | |
| Craniosacral Therapy | | | | Traction | | | |
| Electrical Stimulation | | | | | | | |

Are you currently receiving any of these treatments? Yes No

Medical History *Continued*

Surgery History: Please list any surgeries you have had for other musculoskeletal problems

Surgery Type	Date	Since the surgery do you feel:			Describe the change:
		Better	Worse	Same	
_____					_____
_____					_____
_____					_____

Personal History

In this section we are trying to assess areas of your daily life that could impact your symptoms or your therapy. Please list information that you think is significant and relevant.

Regular Exercise (what type and how often):

Fluid Intake per Day: _____

Dietary Habits (ex. caffeine, alcohol, citrus, nutrisweet, servings of fruits/vegetables):

Sleep Habits (ex. trouble falling asleep or staying asleep): _____

Average Activity Level (ex. Spend work day sitting at a desk):

Are there any other comments or questions that have not been addressed above?



Financial Policy

Insurance

- Pro Motion Physical Therapy is an in-network provider for Medicare, Kentucky Bluegrass, and most BCBS PPO plans. For most other insurance plans, we are out-of-network providers.
- Regardless of whether we are in or out of network with your insurance plan, we can help you understand your benefits so that you know how physical therapy is covered. However, the patient is ultimately fully responsible for knowing his or her own insurance benefits and verification is not a guarantee of payment by the insurance company. Please understand that your insurance coverage is a contract between you and your insurance carrier and we are not a party to that contract.
- As a courtesy, we will directly bill your health, auto or worker's compensation insurance companies. If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier.

Your Financial Obligations

- We accept Visa, Mastercard, checks, and cash. There is a \$25 fee for all returned checks.
- If you have insurance, you are responsible for the following:
 - o Your co-pay/coinsurance at the time of service (per your insurance plan). As a courtesy, patients with multiple visits in a week can pay on a weekly basis.
 - o Deductibles your insurance carrier applies to your coverage.
 - o Any other portion of your bill that is denied or not paid by your insurance carrier
- If you choose to do self pay, we offer a reduced rate if payment is made at the time of your visit. This cannot be billed to your insurance.
- Most insurance companies do not reimburse for medical supplies (such as home exercise equipment or shoe inserts). Payment for these items is expected when you receive them.
- Unless you have already paid us in full, any money paid to *you* by your insurance company for services billed and rendered by Pro Motion Physical Therapy shall be paid to Pro Motion immediately upon receipt.
- Should it become necessary to forward your account to an outside collections agency, you will be responsible for any associated collection, legal, or court fees.

Cancelled/Missed Appointments

Because we reserve time for you to meet one-on-one with your therapist, it is important for us to know if you are not going to be able to keep an appointment so we can offer that time to someone else. Appointments that are missed or cancelled without 24 hours advanced notice are subject to a \$40 fee which is not billable to your insurance company.

Authorizations *(please initial next to each statement and sign below)*

- _____ I have read Pro Motion's financial policy and agree to comply.
- _____ I understand how insurance verification and billing works (if I am in network or out of network).
- _____ I authorize payment of medical benefits from my insurance directly to Pro Motion Physical Therapy.
- _____ I authorize the release of all medical records to referring physicians and my insurance company.
- _____ I agree to accept full financial responsibility for any balance on my account that is not paid by my insurance.
- _____ Pro Motion Physical Therapy has informed me of and provided me with a copy of my rights (Notice of Privacy Practices) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature *(parent/guardian must sign if patient is a minor)*

Date