FREE MOTION
PHYSICAL THERAPY

Patient Name_____
(First) (Last) (MI)

Address_____

_____
City State Zip

Birth Date_____ **Age**_____**Male/Female**

Social Security Number_____

Home Phone (____) _____

Email_____

Employer_____

Address_____

Work Phone_____

Referring Physician_____

Primary Physician_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber Name_____

Subscriber DOB_____

Policy/Claim Number_____

Group Number_____

Employer_____

Secondary Insurance_____

Subscriber Name_____

Subscriber DOB_____

Policy/Claim Number_____

Group Number_____

Employer_____

Marital status: *Married Single Divorced Significant Other Widow/Widower*

Name of Spouse/SO_____

Emergency Contact_____

Relationship to Patient: *Spouse Family Friend Significant Other Parent/Guardian*

Phone Number_____

CONDITION/INJURY INFORMATION

WORK_____
(Date of Injury) (Date of Surgery)

AUTO_____
(Date of Accident) (Date of Surgery)

OTHER_____
(Date of Injury) (Date of Surgery)

MEDICARE PATIENTS:

Date of the Last Visit to your Doctor:_____

_____
Patient Signature

_____
Please Print Date

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PATIENT CONSENT AND RELEASE

FOR _____
(Patient's Full Name)

I hereby authorize treatment by Free Motion Physical Therapy for the above-mentioned patient. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor & Industry claims. I understand that the parent accompanying a minor for treatment will be responsible for payment. I authorize the release of any necessary information requested by my insurance company or attorney and authorize payment directly to Free Motion Physical Therapy.

- If allowed by your insurance, a $50 no-show fee (no-show/no call or cancel within 2 hours of appointment) or $30 cancellation fee (cancel within 24 hours of appointment) will be assessed if you do not show up for your appointment. After (2) no-shows or cancellations we reserve the right to terminate treatment until you are able to commit to regular assigned treatment. We appreciate your understanding with this as we have a limited number of appointment slots.

- We request a $10 yearly charge for exercise equipment given for home exercises. Many insurance companies do not consider exercise supplies a covered benefit.

As a courtesy, we will bill your private insurance for you if we are given a copy of your card and all the information we need to do so, except if you are involved in a third-party claim. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract, therefore, it is the patient's responsibility to determine if there is coverage for the services being rendered, obtain prior authorization if necessary, and follow-up with unpaid visits if necessary. All co-payments are due on the day of treatment per our contract with the insurance companies.

If you are involved with third party litigation, it is our policy not to bill your personal insurance coverage. We will first bill your personal injury protection (PIP) coverage if you have that as part of your own personal car insurance policy. If you do not have PIP coverage as part of your coverage, we will hold all billing until treatment is complete. Once treatment is complete, you and/or your attorney will request the unpaid balance in a demand letter to the party at fault and that balance will be paid directly to Free Motion Physical Therapy in full within 30 days of receiving settlement of the claim. We do this so there is no interruption in treatment waiting on authorization from your personal health insurance.

By signing below you also agree to the following regarding treatment of massage or physical therapy:

1. I give my permission to receive massage or physical therapy.
2. I understand the physical & massage therapist does not diagnose illnesses or prescribe medication.
3. I have clearance from my physician to receive physical and/or massage therapy.
4. I understand the risks of physical and massage therapy my include but are not limited to superficial bruising, short-term muscle soreness and exacerbation of an undiscovered injury. I therefore release the physical and/or massage therapist from all liability concerning these injuries that might occur.
5. I understand the importance of informing the physical and/or massage therapist of all medical conditions and medications I am taking or any changes to these.
6. I understand it is my responsibility to inform the physical and/or massage therapist of any discomfort I may feel during a session so he/she can adjust accordingly.
7. I understand I or the physical and/or massage therapist can terminate the physical therapy or massage session at any time.

Patient/Parent Signature _____

Print Name_____Date _____

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NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

- We may send your referring Doctor, Primary Care Physician, Vocational Rehab Counselor, Nurse Case Manager and L&I Claims Manager any and all initial evaluations, progress notes, lift assessments, and discharge summaries so that they are kept apprised of your progress and to authorize continued treatment at Free Motion Physical Therapy.

- You are entitled to a copy of any and all chart notes, reports and billing statements within our possession and may request them at any time.

- We may use your personal information to obtain a referral authorization from your Primary Care Physician or Specialist so that your insurance company will cover the cost of your treatment.

- If you are involved in a third-party litigation, any law firm involved in the case may request copies of any and all chart notes, reports and billing statements within our possession. We must receive a signed consent from you to release this information.

- We may use your information to verify benefits, co-payment amounts and billing information with your insurance company.

- Your insurance company may request copies of any and all chart notes, reports and billing statements within our possession.

- We may release your personal information to our in-house billing service at Free Motion Physical Therapy, so we may bill your insurance company for the services provided by this office.

- You are entitled to request any and all names of companies and individuals that have requested your information from this office.

By signing below, I acknowledge that I have read and understand how my Personal Health Information may be used and disclosed by Free Motion Physical Therapy.

Signature _____ Date _____

Print Name _____

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PHYSICAL THERAPY

Patient Name:_____ **Date:**_____

1. How did your problem begin?_____

_____

2. What are your primary complaints?_____

_____

3. Past/present treatments for this condition:_____

4. Previous physical therapy: ☐ Yes ☐ No When: _____ How many visits:_____

5. Do you have, or have you had any of the following?

☐ Diabetes	☐ Gallbladder Problems
☐ Chest pain / Angina	☐ Stroke / CVA
☐ High Blood Pressure	☐ Hernia
☐ Heart Attack	☐ Seizures
☐ Pacemaker	☐ Recent Fractures
☐ Kidney Problems	☐ Nausea / Vomiting
☐ Cancer	☐ Rheumatoid Arthritis
☐ Osteoporosis	☐ Hypoglycemia
☐ Asthma	☐ Surgeries_____
☐ Liver Problems	Other_____

6. Please list all Medications:_____

_____

7. Have you had similar problems in the past? ☐ Yes ☐ No

   If so, please explain:_____

8. What is your occupation/hobbies?_____

9. Are you currently working? ☐ Yes ☐ No

   If not, is it due to your condition? ☐ Yes ☐ No

10. Just prior to the onset were you completely free of symptoms?

    ☐ Yes ☐ No

11. Does anything make your pain worse**?** ☐ Yes ☐ No

    If so, what?_____

12. Does anything ease your pain? ☐ Yes ☐ No

    If so, what?_____

13. Are you able to get comfortable at night? ☐ Yes ☐ No

14. How do you feel upon rising in the morning? ☐ Stiff ☐ Sore ☐ Fine

15. Once you start moving about does it ☐ Worsen ☐ Ease

16. What is it like at the end of the day? ☐ Better ☐ Worse ☐ No Change

17. At this time, do you feel that you are getting? ☐ Better ☐ Worse ☐ No Change

18. Pain Level: 1 2 3 4 5 6 7 8 9 10