ProMotion
PHYSICAL THERAPY

Date: _____ Who can we thank for telling you about us? _____

Patient's Full Name: _____ _____ _____
First Middle Last

Preferred Name: _____

Address: _____ City: _____ State: ____ Zip: _____

DOB: _____ Age: _____ Marital Status: S M W D

Email: _____ Male: _____ Female: _____

Primary Phone: _____ Cell/Home

Secondary Phone: _____ Cell/Home

Patient's Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone: _____

Minor's Only: Parent's Name: _____ Phone: _____

Parent's Employer: _____ Phone: _____

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Family Physician: _____ Date of doctor visit for this injury: _____

Have you had any of the following medical or rehabilitative services for this ailment?

	YES	NO		YES	NO
General Practitioner	____	____	Massage Therapy	____	____
Chiropractor	____	____	Occupational Therapy	____	____
Neurologist	____	____	Physical Therapy	____	____
Orthopedist	____	____	Date of Physical Therapy this year? ____/____/____		
Podiatrist	____	____	Home Health Services	____	____
Emergency Room Care	____	____	List which ones: _____		

Other _____

Have you ever had any of the following injuries or ailments?

	YES	NO		YES	NO
Allergies	____	____	High/Low Blood Pressure	____	____
Anemia	____	____	Infectious Disease	____	____
Arthritis / Swollen Joints	____	____	Joint Replacement	____	____
Asthma / Emphysema	____	____	Numbness or Tingling	____	____
Auto Immune Disorder	____	____	Pacemaker	____	____
Blood Clot / Embolism	____	____	Pins or Metal Implants	____	____
Bowel / Bladder Problems	____	____	Shortness of Breath/Chest Pain	____	____
Cancer	____	____	Sleeping Difficulties	____	____
Coronary Heart Disease	____	____	Stroke / TIA	____	____
COVID-19	____	____	Thyroid Disorder / Goiter	____	____
Diabetes	____	____	Unexplained Weight Loss	____	____
Dizziness or Fainting	____	____	Varicose Veins	____	____
Emotional/Psychological	____	____	Vision or Hearing Difficulties	____	____
Epilepsy / Seizures	____	____	Weakness	____	____
Gout	____	____	Are you pregnant?	____	____
Headaches - Severe/ Frequent	____	____	Do you smoke?	____	____
Heart Attack/Surgery	____	____	Other	____	____
Hernia	____	____			

Explain any "Yes" answers from above: _____

_____

Have you had COVID-19 vaccines & boosters? YES or NO If Yes, list month/year of each shot _____

_____

List all medications you are currently taking: _____

_____

List all previous surgeries and serious skeletal or muscular injuries (include dates): _____

_____

What are your expectations/goals while in our program care? _____

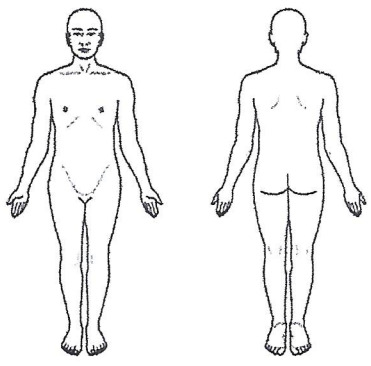
_____

INITIAL PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

1. What is the main reason you are here? _____
2. When did the problem FIRST occur? _____
3. Please describe: _____
4. How have you treated the problem?
   - Pain Medications? Yes /No List _____
   - Injections? Yes /No When? _____
   - Physical Therapy? Yes /No Where and When? _____
   - Surgery? Yes /No Where and When? _____
5. What type of doctors have you seen for this problem? _____
   _____
6. What is this keeping you from doing? _____
7. Circle the diagnostic studies have you had done for this problem:
   X-Rays CT Scan MRI Bone Scan Myelogram Other: _____
8. Circle the best description(s) of your pain:
   Dull Aching Knifelike Stabbing Radiating/Shooting
   Sharp Burning Throbbing Pins/Needles
9. Rate your pain on a scale of 0 to 10: 0----------5----------10
   Pain Free Moderate Worst Pain Ever

   Pain at your BEST_____ Pain at your WORST_____ Pain TODAY_____
10. Circle the things that make your pain worse:
    Sitting Standing Lying Walking Cold Heat Lifting Bending Rain
    Coughing/Sneezing Other: _____
11. Circle the things that make your pain better:
    Sitting Standing Lying Walking Bending Ice Pack Massage Heating Pad
    Hot Shower/Bath Other: _____
12. Circle when your pain is present:
    At rest With movement
    Explain: _____
13. Do you also have numbness? Yes/No
    If yes, where? _____
14. Please illustrate your pain.



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Acknowledgement of ProMotion Physical Therapy Policies

**Please initial each line below and sign & date the bottom

Consent to Treat

_____I understand that Federal Law requires me to be given a free choice of healthcare providers. I have chosen ProMotion Physical Therapy to be my healthcare provider until I direct otherwise. I hereby authorize and consent to the care and treatment: tests, procedures, medical treatments, diagnostic and otherwise, as the therapist and my doctor consider to be necessary and appropriate. I understand that it may be necessary for my blood to be tested for HIV antibodies, Hepatitis B, and/or other infectious diseases, if the therapist or other staff comes in contact with blood or other infecting body fluid, other than saliva, urine, or vomit.

_____I hereby authorize Amanda Pilz, MPT, and whomever she may designate as her assistants to administer the prescribed treatment program, and such additional treatment or procedures as are considered therapeutically necessary based on findings during the course of said treatment. I also certify that no guarantees or assurances have been made as to the results that may be obtained.
Copayments and deductibles will be collected at the time of service and prior to your appointment. Payments toward deductibles and/or co-insurance is an estimated amount of patient responsibility. Actual patient responsibility will be determined after claims are processed and patient will be billed for any additional amount due.
**NOTE TO PATIENT: WE STRONGLY ADVISE THAT YOU CALL YOUR INSURANCE COMPANY AND VERIFY THE INFORMATION WE RECEIVED ON YOUR BENEFITS.

Cancellation and No-Show Policy

_____ There is a no show/cancellation fee of $50 if less than 24 hours notification is given prior to the scheduled appointment. This fee is the responsibility of the patient. We will continue to provide a high standard of care, and we ask that you commit to your scheduled appointment.

Benefit Assignment/Release of Information

_____I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to ProMotion Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment by these parties. If you wish for information about your condition to be provided to another party not mentioned within, a written request must be provided by them, and authorization must be signed by you.

Financial Policy Statement

_____ProMotion Physical Therapy will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, you are responsible for the balance. You understand that your co-pay amounts will be due at each date of service and that you are ultimately responsible for your bill. A finance charge of 1.5% monthly (18% annual percentage rate) will be added to your outstanding account balance after 30 days. ProMotion Physical Therapy reserves the right to discontinue therapy if your patient responsibility balance exceeds $200. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to ProMotion Physical Therapy.

_____ **(Worker's Compensation patients only)** The above financial policy does not apply for those patients who are considered Worker's Compensation (W/C). However, be advised, if you claim W/C benefits, and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

You understand, and agree, that if you fail to make any of the payments for which you are responsible, in a timely manner, you will be responsible for all costs of collecting monies owed, including interest, collection agency fees, court costs, and attorney fees.

It is important to maintain the consistency of care recommended by your physical therapist to meet your goals. If you miss 2 appointments without communication with our office at least 24 hours prior to your appointment, we reserve the right to discontinue your case.

Privacy Practices Acknowledgment

_____I have read and fully understand ProMotion Physical Therapy's Notice of Privacy Practices.

_____I understand that ProMotion Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment, or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations, if I notify the practice. I also understand that ProMotion Physical Therapy will consider requests for restriction of information on a case-by-case basis but does not have to agree to these requests.

_____I hereby acknowledge my awareness of the use and disclosure of my personal health information for purposes as noted in ProMotion Physical Therapy's Notice of Privacy Practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

By signing below, I acknowledge that I have read and agree to these policies.

Patient Name (Print): _____

Signature: _____ Date: _____