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

Patient's Full Name: _______________ __________________ ______________________
First Middle Last

Address: ____________________________ City: _______________ State: ___ Zip: _______

DOB: _________________ Age: ______ Marital Status: S M W D

Social Security Number: _______-_____-_______ Male: _____ Female: _____

Home Phone: ___________________________ Cell Phone: ____________________

Preferred Phone__________________________________

Email: ____

Patient's Employer: _______________________________Work Phone:__________________

Emergency Contact Person: _____________________________Phone: _________________

Minor's Only: Parent's Name:____________________Phone: _____________

Parent's Employer:_________________Phone:______________

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 also 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 on the basis of 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.

Patient Name (print): ______________________ Patient Signature: _____________________

Parent/Guardian Name: _____________________ Signature: __________________________

Date: _________________________

PATIENT MEDICAL HISTORY

Name: ___________________________ Referring Physician: ___________________

Family Physician: __________________ Date of Dr. visit for this injury: ____________

Surgery due to this injury? ___________ Number of surgeries: __________

Type of surgery: ___________________ Location of surgery: ____________________

Are you currently taking any medications? _____________

List all medications:

____

Had you had any of the following Medical or Rehabilitative Services for this ailment?

	YES	NO		YES	NO
Chiropractor	____	____	CT Scan	____	____
EMG/NCV	____	____	General Practitioner	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room Care	____	____	X-Rays	____	____

Other ____

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

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

Explain any "Yes" answers from above:

____

List all previous surgeries, and serious skeletal or muscular injuries, with dates:

____

Any additional information you feel is relevant to your care:

____

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

____

INITIAL PAIN 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. Who are the doctors you have seen for this problem?
   ____
6. What functions are limited? ______________________________________
7. What studies have you had done for this problem?
   X-RAYS CT SCAN MRI BONE SCAN OTHER
8. Is your pain:
   ___Dull ___Sharp ___Aching ___Knifelike ___Stabbing
   ___Throbbing ___Radiating/Shooting ___Burning __Pins/Needles
9. On a scale from 0 to 10, rate your pain.
   (O = Pain-free; 5 = Moderate pain; 10 = Worst pain ever)
   *Circle 3 numbers, indicating your pain levels at BEST, at WORST, and TODAY.
   0-------1--------2--------3--------4--------5--------6--------7--------8--------9--------10
10. What makes your pain worse?
    ___Sitting ___Standing ___Lying ___Walking ___Bending
    ___Lifting ___Rain ___Cold ___Heat ___Coughing/Sneezing
    ___ Other ____
11. What makes your pain better?
    ___Sitting ___Standing ___Lying ___Walking ___Bending
    ___Hot Shower/Bath ___Heating Pad ___Ice Pack ___Massage
    ___Other ____
12. When is your pain present?
    ___At rest ___With movement
    Explain: ____
13. Do you also have numbness? ___Yes ___No
    Where? ____
14. Please illustrate your pain.

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. By signing the bottom of this form, I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment by these parties.

MEDICAL RECORDS
Your medical records are held in the strictest confidence. If you wish information about your condition to be provided to another party not mentioned above, they must provide us with written authorization signed by you, along with their request.

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, the balance will be due in full from you. 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.

The above does not apply for those patients that 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.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please ask for our assistance.

By signing below, I acknowledge that I have read this policy, and understand that I am responsible for the payment of my account.

____________________________________ ________________________
Signature of Patient/Guardian/Responsible Party Date

____
Name (Print)

**NOTE TO PATIENT: WE STRONGLY ADVISE THAT YOU CALL YOUR INSURANCE COMPANY AND VERIFY THE INFORMATION WE RECEIVED ON YOUR BENEFITS.

Notice of Privacy Practices

ProMotion Physical Therapy is required by law to provide you with our Notice of Privacy Practices so that you will understand how we may use or share information from your Designated Record Set. The Designated Record Set includes financial and health information which from here on out will be referred to as Protected Health Information or PHI. Our facility is required to adhere to the terms outlined in this notice. If you have any questions after carefully reviewing this document, please contact ProMotion Physical Therapy's Privacy and/or Security Officer.

Understanding Your Health Record and Information

Each time you visit ProMotion Physical Therapy, a record of your visit is made. This record contains health and financial information. This record may also contain information about your condition, the type of treatment provided and payment for the treatment. We may use or disclose this information to the following:

- Plan your care and treatment
- Communicate with other health professionals involved in your care
- Document the care you receive
- Educate professionals
- Provide information for medical research
- Provide information to public health officials
- Evaluate and improve on the care ProMotion provides
- Obtain payment for the care we provide

How We May Use and Disclose Protected Health Information About You

ProMotion Physical Therapy uses your PHI primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, ProMotion Physical Therapy may use your Protected Health Information to contact you to provide appointment reminders, to give you information about treatment alternatives or other health related benefits that could be of interest to you.

ProMotion Physical Therapy may also use or disclose your PHI without prior authorization for the following: public health risk purposes, auditing purposes, research studies, worker's compensation, organ and tissue donation, military and veterans and emergencies. We also will provide information when required by law.

In all other situations, ProMotion Physical Therapy is required to obtain your written authorization before disclosing your Protected Health Information. ProMotion Physical Therapy is also responsible for knowing who else besides the patient is allowed to be privy to your PHI such as a family member or guardian. A patient's PHI will only be disclosed or discussed with a person other than the patient, only if the patient has authorized us to do so. A patient also has the right to decide how their PHI is used or transmitted to them. For example, can ProMotion leave a voice mail regarding your upcoming appointment? Can we contact you by mail or email? Can we use information for marketing purposes such as newsletters, websites and photographs? Appropriate forms, asking you these questions and giving you choices as to what can be released and to who, will be provided to you upon your first visit.

If you provide us with written authorization to release your information for any reason, you may later, in writing, revoke that authorization or change it, to stop future disclosures, at any time. If you revoke your permission, ProMotion Physical Therapy will no longer use or disclose health information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided for you.

From time to time, due to updated regulations, changes within our organization or to better meet your needs, the Notice of Privacy Practices will be updated. When this happens, all active patients will receive the updated version of the document, the new notice will be posted in the waiting room, in all of the exam rooms and on our website. You may also request a copy of the latest Notice of Privacy Practices from us at any time, even if you have received the notice electronically.

Your Rights Regarding Health Information About You

Although your health record is the property of ProMotion Physical Therapy, the information belongs to you. You have the right to review or obtain a copy of your personal health information at any time. There may be a nominal fee for the costs of copying, mailing or other supplies associated with your request.

As the patient, you have the right to request in writing, that we correct any inaccurate or incomplete information in your records. If you feel that the health information in your record is inaccurate, you may ask us to amend the information. We have the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that did not originate from our office, is not part of the health information kept by or for the facility or is inaccurate or incomplete.

You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. The request must be submitted in writing to the Facility Director. The written request must state a time period which may not be longer than 6 years from the date the request is submitted and may not include dates prior to April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Additionally, you may request in writing, that we do not use, or disclose, your PHI for treatment, payment, and administrative purposes, except when specifically authorized by you, when required by law or in emergency circumstances. As a patient, you also have the right to restrict disclosures to an insurance company or health plan concerning your treatment, if you have paid ProMotion's fees in full and in cash. ProMotion Physical Therapy will consider all such requests on a case by case basis.

We are not required to agree with your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. We will give you our answer in writing.

Risk Assessment Protocol for Disclosure of PHI

ProMotion Physical Therapy works hard to insure that all the PHI of a patient is protected and secure. ProMotion Physical Therapy is committed to taking all the necessary steps and measures to keep our patient's information from becoming unnecessarily disclosed. There may come a time when unfortunately we encounter a breach of a patient's PHI. At that time, ProMotion Physical Therapy will do everything they can to correct the breach and/or determine that the disclosed information did not constitute a breach. ProMotion will do the following if a breach of PHI has been determined:

- Determine the nature and extent of the breach. Identify whether the breach was low, medium or high risk.
- Determine the recipient of the breach.
- Determine who is affected by the disclosure.
- Determine the PHI that was acquired or viewed.
- To what extent has the identified risk been mitigated following the breach?

Depending on the findings of the risk assessment of the disclosed PHI, ProMotion Physical Therapy will then follow the protocol outlined in their Breach Notification Policy based on HIPAA guidelines and adopted by ProMotion as their office policy.

Concerns and Complaints

We strive to take all of the necessary precautions making sure that each individual's Protected Health Information is not leaked or disclosed in a way that it compromises the security of the patient's PHI and in turn presents a risk of financial, reputational or other harm to the affected individual. If you are concerned that ProMotion Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your PHI, please contact our HIPAA Privacy Officer. You may also contact in writing, the US Department of Health and Human Services, Office of Civil Rights. For more information on ProMotion Physical Therapy's HIPAA practices or to file a formal complaint, please contact:

ProMotion Physical Therapy

20 Grayson New Hope Road, Suite C

Grayson, GA 30017

770-682-3854 or 770-554-7977

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.

Patient Name: ____

Signature: _____________________________Date: _______________________

Cancellation and No-Show Policy

ProMotion Physical Therapy is committed to offering you the best possible treatment administered by our highly skilled staff. We go to great lengths to ensure that your treatment experience is successful in achieving a rapid recovery. We have attempted to be flexible with our hours of operation, and try to accommodate our patients' schedules, without making them wait to get in for an appointment. However, any no-shows or cancellations made within 24 hours of a scheduled appointment means that we have an unusable time slot. Therefore, cancellations and no-shows made within 24 hours of a scheduled appointment will be billed at a rate of $25 per occurrence. We will continue to provide the high standard of care, and we ask that you commit to your scheduled appointment. Your insurance company will not cover this fee; therefore, it will be your responsibility.

By signing below, I acknowledge that I have read and agree to this policy.

Patient Name: ____

Signature: _____________________________Date: _______________________

20-C Grayson New Hope Road
Grayson, GA 30017
770-682-3854
770-682-3824 Fax

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

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 Name

_________________________________ Date: ________________
Patient Signature

Financial Policy
2018

As you know, the healthcare industry continues to change and evolve. In order to maintain our low rates and excellent service, ProMotion has had to make some changes as well. Please make note of these changes:

1) Your doctor and/or therapist will prescribe a Treatment Plan for you. Effective January 1st, 2016, we will be scheduling your complete plan of care at the time of service. For example, if your Treatment Plan is for two times per week for four weeks, we will schedule all 8 visits at once. This change will enable you to get the time you desire, while ensuring everyone gets the care and treatment they need.

2) Copayments and deductibles will be collected at the time of service and prior to your appointment. Multiple visits may be paid in advance.

3) No Show Fees: There is a no show/cancellation fee of $25 if less than 24 hours notification is given prior to the scheduled appointment. **This fee is not covered by your insurance or worker's compensation program.** It is important for the optimum outcome of your physical therapy intervention that you make your appointments a priority. Please work with us and make every effort to keep your appointments.

Thank you for your continued support. We look forward to a happy and healthy 2018!

ProMotion PT