ProMotion
PHYSICAL THERAPY

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 payors 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.

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Cancellation and No-Show Policy

Dear Patient,

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 Printed Name

______________________________ _______________
Patient Signature Date

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Consent to Treat

I understand that Federal Law requires me to be given a free choice among healthcare providers. I have chosen ProMotion Physical Therapy to be my healthcare provider until I later direct otherwise.

I hereby authorize and consent to the care and treatment; including tests, procedures, and medical treatments, diagnostic and otherwise, as the therapist and my physician 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 comes in contact with blood or any other infecting body fluid, other than saliva, urine, or vomit.

I, the undersigned patient of ProMotion Physical Therapy, 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 (If Over 18) ______________________________

Parent/Guardian Name (Print) ______________________________

Parent/Guardian Signature ______________________________

Date ______________________________

3/2010

3890 Highway 81 South
Loganville, GA 30052
770-554-7977

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

Patient Information Acknowledgment Form

I have read and fully understand ProMotion Physical Therapy's Notice of Information 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 Information Practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

Patient Name: ____

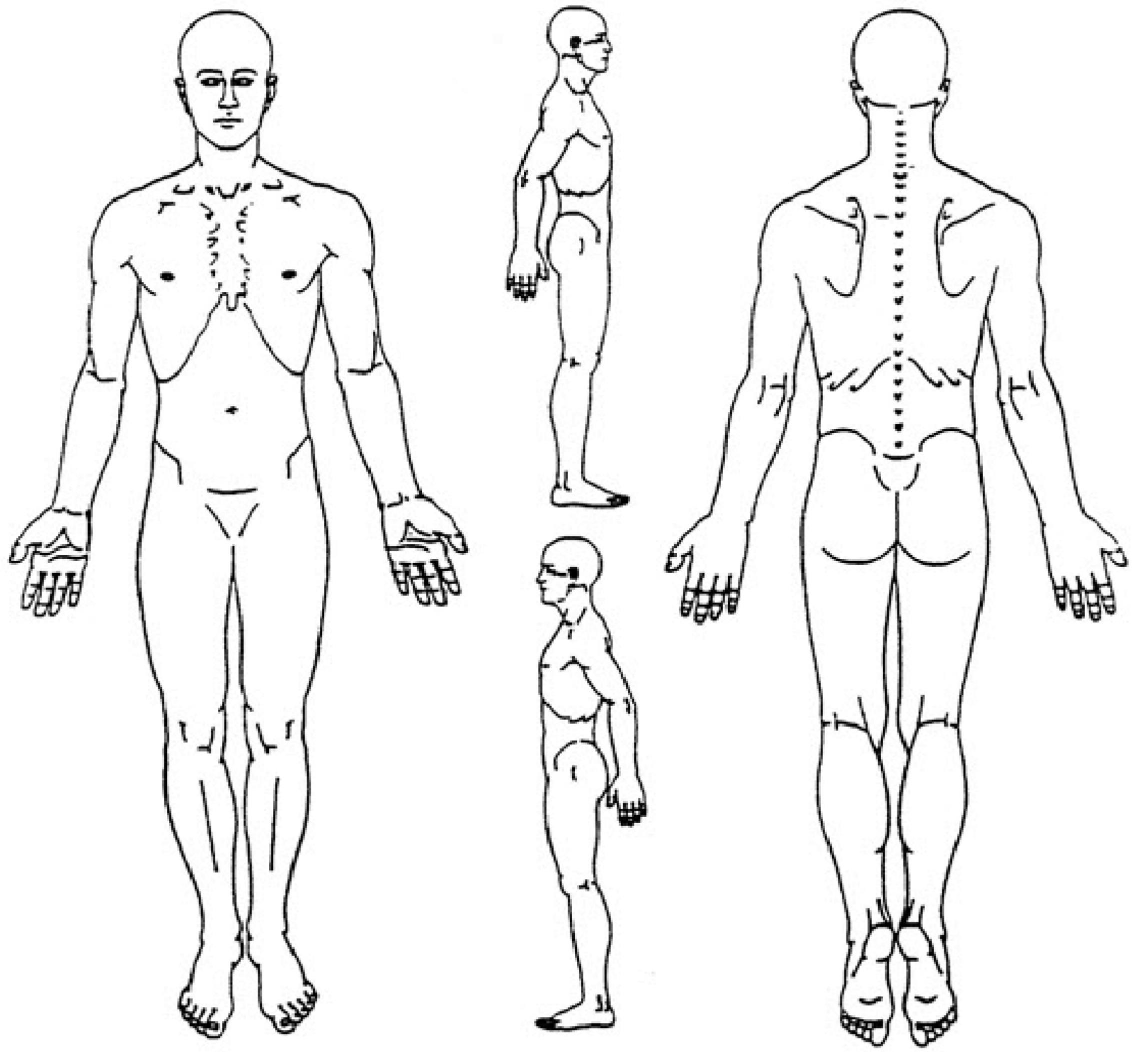
Signature: ____

Date: ________________________

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. 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 ___Knifelife ___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.



Notice of Patient Information Practices

This notice describes how medical information about you may be used, or disclosed, and how you may gain access to information. Please review it carefully.

PROMOTION PHYSICAL THERAPY'S LEGAL DUTY

ProMotion Physical Therapy is required, by law, to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

ProMotion Physical Therapy uses your personal health information 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 personal health information to contact you to provide appointment reminders, to give 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 personal health information, without prior authorization, for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any other situation, ProMotion Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization, to stop future disclosures, at any time.

ProMotion Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas, and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. 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.

You may also request, in writing, that we not use, or disclose, your personal health information for treatment, payment, and administrative purposes, except when specifically authorized by you, when required by law, or in emergency circumstances. ProMotion Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

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 personal health information, please contact our practice manager. You may also send a written complaint to the US Department of Health and Human Services. For further information on ProMotion Physical Therapy's health information practices, or if you have a complaint, please contact:

ProMotion Physical Therapy

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?
____

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Date: ________________ Referring Physician: __________________

Patient's Full Name: ____
First Middle Last

Address: ______________________ City: _____________ State: ___ Zip: ______

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

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

Primary Phone: ____________________ Secondary #: ______________________

Email: _________________________________

Patient's Employer: _____________________Work Phone:___________________

Spouse / Parent's Name: ________________________Phone: ________________

Social Security Number: ______-____-______ DOB: __________ Age: ______

Spouse / Parent's Employer: _________________________Phone: ___________

Contact Person NOT living with you: _____________________ Phone:_________

Primary Insurance

Company: ______________________ Name of Policy Holder: ________________

Relationship to Patient: ___________ DOB: ________ SS #: ____-____-______

Policy #: ____________________ Group #: ___________ Phone: ____________

Claims Address: ____

Secondary Insurance

Company: ____________________ Name of Policy Holder: __________________

Relationship to Patient: ____________ DOB: ________ SS#: _____-____-_____

Policy #: _____________________Group #:___________ Phone: ___________

Claims Address: ____