

How did you hear of us? MD Friend Newspaper Advertisement Other: _____

PATIENT INFORMATION (Please PRINT all information) * Please list today's date _____

Patient name _____ If minor, Parent name also _____

Patient Social Security # _____ If minor, Parent SS# also _____

Patient Date of Birth _____ If minor, Parent Date of Birth also _____

Address _____

City _____ State _____ Zip _____

If P.O. Box, please list street address _____

Home phone _____ Cell phone _____

Employer _____ If minor, Parent employer _____

Work phone # _____ If minor, Parent work # _____

Physician _____ Location / Name of Clinic _____

Is this a worker's compensation claim? *(see note on bottom of page) YES NO **Injury date** _____

Is this a motor vehicle accident claim? *(see note on bottom of page) YES NO **Accident date** _____ **State** _____

Electronic Statement

_____ Please check here if you would prefer to receive your bill electronically to the email address below.

Security Question: Which city were you born in? _____

Email Request Form

Back in Motion Physical Therapy and Sports Medicine requests your Email address in order to provide you with important medical information on a timely basis.

We assure you that we will **NOT** share your Email address with any 3rd party.

Primary Email address

Patient's name (please Print)

Patient's Signature

Date

FINANCIAL POLICY

Thank you for choosing Back in Motion Physical Therapy and Sports Medicine, Inc. as your physical therapy provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment.

- Patients should provide accurate and complete personal and insurance information prior to being seen by the therapist.
- Co-pays are due at each appointment.
- Deductibles, personal balances, both current and prior, are due at time of service.
- We accept cash, check.

Regarding Health Insurance: We participate in numerous insurance plans. For most insurances, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be *personally* liable for the balance not covered by insurance. Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company. We will work with you to determine the extent of your insurance coverage and payment options; however, we recommend that you contact your health insurance provider to verify your coverage. In cases of financial need and other circumstances, billing adjustments may be an option.

Past Due Accounts: 1 ½% interest will be added to patient balances over 30 days. If your account becomes overdue, it may be referred to a collection agency and/or lawyer. Legal fees that we pay to secure past due balances will be added to your account. In case of suit, you agree the venue shall be in Dane County, Wisconsin. In the event your account is submitted to an outside source for collection, you give your permission to release the necessary information, personal or otherwise, to the outside source and you are aware that this information may become a matter of public record.

Returned Checks: A \$35.00 fee will be charged for each check returned to us unpaid by your bank.

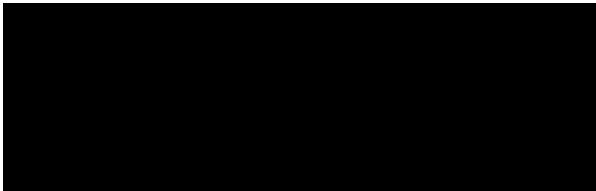
I have read the Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Back in Motion Physical Therapy and Sports Medicine, Inc. Furthermore, I agree to assign all health insurance benefits directly to Back in Motion Physical Therapy and Sports Medicine, Inc. If the patient is a minor (under age 18), a parent or legal guardian must sign this agreement.

PRINT Patient's Name

Signature of Patient, Parent, or Legal Guardian

Today's Date: _____

Would you like a copy of our HIPPA privacy notice? YES NO Received _____ Refused _____



5802 Hwy 51, Unit 2, McFarland, WI 53558
Phone: 608.838.7232 Fax: 608.838.7405
www.getbackinmotion.net

Cancellation and No Show Policy

Dear Patient,

In order to schedule patients with the care that they need, and for the consideration of other patients, Back in Motion Physical Therapy and Sports Medicine requires:

- *A 24 hour cancellation notice if a patient is unable to keep a scheduled appointment time.*
- *If a patient fails to show up for an appointment without notifying the office, a \$20.00 fee will be charged to the patient for the missed appointment.*
- *If you call in advance, there will be no charge.*

If a patient misses 2 appointments without calling, Back in Motion Physical Therapy and Sports Medicine will make every effort to contact the patient to reschedule the appointments. If no contact is made, all additional appointments will be removed to allow for accommodation of other patients.

If you have any questions regarding this policy, please discuss it with your therapist.

I have read the Cancellation/No Show Policy and I agree to the terms and conditions outlined within this policy:

Signed _____ **Date** _____

Name: _____ SSN: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

I should not do physical activities that might make my pain worse: Disagree Unsure Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

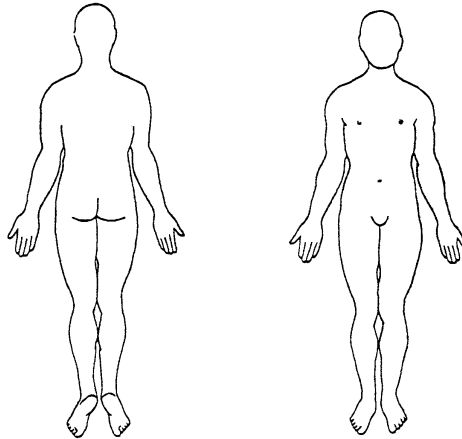
Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

FOR WORKER'S COMPENSATION OR MOTOR VEHICLE ACCIDENT PATIENTS ONLY:

Name of worker's compensation or motor vehicle insurance to where bills should be sent: ***(If you are unsure of where bills should be sent, please list your work phone number or your auto insurance carrier name and phone number below on "phone number" line below.)**

Insurance company _____

Claim # _____

Address _____

City _____ State _____ Zip _____

Phone number _____

***Please note: If you are a worker's compensation or motor vehicle accident patient, and you have personal health insurance, we require that you supply us with this secondary information in the event that worker's compensation or the motor vehicle insurance would deny your claim. Please be aware that you will be responsible for any outstanding balance that may arise from a denial.**

Initial _____