Patient Registration

Name____ **DOB**__________
Last First MI

Mailing Address ____
Street City State Zip Code

Physical Address (*If different from mailing)*____
Street City State Zip Code

Cell Phone w/area code______________________ **Work Phone**________________________ **Home**_____________________

Email Address____

Contact Preference: Home_____ Work_____ Cell_____ **Notification Preference:** Call_____ Text_____ Email_____

Marital Status: Single____ Married____ Domestic Partner____ **Sex: Male**______ **Female**_____

Emergency Contact___________________________________ **Phone #**_______________________ **Relation:**______________

Employer___________________________________ **Employer Address** ____

Primary Care Physician_____________________________**Referring Physician**_____________________________________

If not referred from physician where did you learn about Pro Motion Physical Therapy______________________________

Insurance Information – Please give your cards to the front desk for scanning

Primary Insurance ____

Subscribers Name____ **Birthdate**_________________________

ID Number____ **Group Number** _________________________________

Secondary Insurance ____

Subscribers Name____ **Birthdate**_________________________

ID Number____ **Group Number** _________________________________

If you had an accident please complete this section

Date of accident_______________ **Cause of accident: Auto**___ **Work**___ **Other**___ **State in which injury occurred**____

Insurance ____________________ **Claim Number (worker's comp or your auto PIP)**_______________________________

Address_________________________ **Claims Adjuster**_________________________ **Phone Number**________________

I verify that the above information is accurate (Signature)____

Authorization to Disclose Medical Records

This authorization must be dated and signed by the patient or by a person authorized by law to give authorization.

I authorize Pro Motion Physical Therapy to release a copy of the medical information for

____ **to** ____

Patient Name **Name of Company**

By initialing the spaces below, I authorize the release of the following medical records:

____ Clinician's Chart Notes ____ Billing Statements ____ Other: ________________________________

____ Please send the entire medical record to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

____

Signature of patient/ Guarantor Date

Informed Consent for Physical Therapy Treatment

Physical therapy involves the use of many different types of treatment and evaluation techniques. At Pro Motion we use a variety of procedures and modalities to help improve your function deficit and pain. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular therapy might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain, damage or may aggravate previously existing conditions. Modalities used in our clinic can at times cause skin irritation such as skin discoloration and skin sensitivity. These modalities include but are not exclusive to suction therapy, electric stimulation, laser and ultrasound. You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing about any specific risks associated with your exercises, your therapist will be glad to answer them.

______ (initial) I voluntarily consent to evaluation and treatment by Pro Motion Physical Therapy, and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

______ (initial) I give authorization to Pro Motion Physical Therapy to use my testimonials and quotes for use on the Pro Motion Physical Therapy's web site, newsletter, Facebook, Twitter, advertising and correspondence.

I acknowledge that my treatment program has been explained by Pro Motion Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed. I certify that I have read the *Payment Agreement*, *Missed Appointment/Late Cancellations*, *Informed Consent for Physical Therapy Treatment*, *and Authorization and Release of Information* sections above and agree to all statements contained therein.

____ _____________________

Patient Signature/ Guarantor Date

____ _____________________

Printed Name Relation

Payment Agreement

As a service to our patients, Pro Motion is happy to submit charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for the payment of the account balance.

______(initial) I understand that prompt payment for all therapy services is my responsibility.

We are committed to providing the best possible care for each patient. Our fees lie within the acceptable range by most companies and should be covered up to the maximum allowance determined by each provider. Not all services are covered in all contracts. To help you receive the maximum benefit from your insurance provider, we need your assistance and understanding of our payment policies.

______(initial) I recognize it is my responsibility to understand my insurance policy and coverage.

Medicare- We accept assignment and we will bill Medicare for you. Medicare pays 80% of the approved amounts and does not allow us to write off any portion of the 20% co-pay or deductible. Please understand that payment in full for all charges is your responsibility.

______(initial) I authorize payment of medical benefits to Pro Motion Physical Therapy, and understand this payment agreement.

Missed Appointments/ Late Cancellations

______(initial) My appointment time is reserved specifically for me. If an appointment is cancelled with less than 24 hours notice I________________________________ will be given a verbal warning on the first occurrence, and charged a $30.00 fee for subsequent occurrences. In the event of a missed appointment with no prior notification I will be charged $65.00. I understand insurance will not pay for a missed appointment or late cancellation fee.

______(initial) I agree to be responsible for the payment of all services incurred while in the care of Pro Motion Physical Therapy. I understand that this may include deductible, co-pay, and co-insurance as well as any charges not covered by my insurance company(s). If my insurance denies payment of a a claim, I will be responsible for the billed charges.

Notice of Patient Privacy
Health Insurance Portability and Accountability Act (HIPPA)

Pro Motion Physical therapy is dedicated to preserving your personal health information. we are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law:

* We must have written consent before we use or disclose your medical information to others for the following purposes:
  - providing or arranging your healthcare
  - payment for reimbursement of treatment
  - provided and related administrative activities supporting your healthcare

* We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.
* Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, or a crime of domestic violence.
* Your protected information may be disclosed if you are involved in a lawsuit or dispute, through a court or administrative order or in response to a subpoena.
* We may disclose health information about a minor child equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.
* You are provided the right to inspect and receive a copy of your medical information, amend or correct that information, obtain an accounting of or disclosures of your patient file, request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and complain if you think your rights have been violated.
* Pro Motion Physical Therapy will abide by the terms of this notice. at any time, Pro Motion Physical Therapy reserves the right to make changes to this notice an will continue to maintain the confidentiality of all health information. Changes to this notice will be redistributed at our next visit to Pro Motion Physical Therapy.
* All complaints will be investigated. No personal issue will be raised by filing a complaint with Pro Motion Physical Therapy.
* If you have any questions, concerns or complains about the NOTICE or your medical information, please contact Pro Motion at (541) 390-0523. You may also send a written complaint to the US Department of Health and Human Services.

______________________________ ______________

Patient Signature/ Guarantor Date

______________________________ ______________

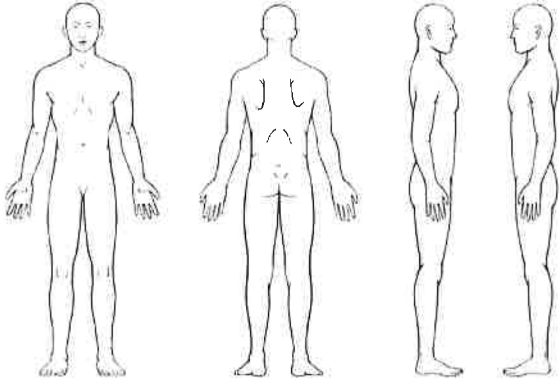
Printed Name Relation

HEALTH QUESTIONNAIRE

1.Reason for visit?______________________________

____

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)



2. When did your symptoms begin?__________________
(*please indicate a specific date if possible*)

3. Was the **onset/timing** of this episode?
☐ gradual ☐ sudden

Any previous episodes ☐ Yes ☐ No

4. Which of the following best describes how your injury occurred? (*If your condition is post-surgical, please indicate as per original injury*)

☐ Unknown ☐ Degenerative Process
☐ while lifting ☐ an incident at work
☐ MVA (accident) ☐ Dental appointment
☐ a fall ☐ during recreation/sports
☐ trauma ☐ overuse (cumulative trauma)
☐
other______________________________

5. Since the onset, are your symptoms? (*Check one*)
☐ Improving ☐ Not changing ☐ Worsening

6. Have you had any fall(s) in the past year? ☐ No
☐ Yes, how many times____; ☐ Injured ☐ Not injured

7. Nature of pain/symptoms (*Check all that apply*)
☐ sharp ☐ aching ☐ constant
☐ dull ☐ periodic ☐ other__________
☐ throbbing ☐ occasional

As the day progresses, do your symptoms (*Check one*)
☐ increase ☐ decrease ☐ stay the same

Does the pain wake you at night?
☐ No ☐ Yes, if "yes", is it present
☐ While laying down ☐ only when changing positions
☐ Both

Do you have pain/stiffness upon getting out of bed in the morning? ☐ Yes ☐ No

8. In what position do you sleep (*Check all that apply*)
☐ Back, sides, stomach ☐ Right side
☐ Left side ☐ Stomach
☐ On back ☐ Chair/Recliner

9. Since the onset of your current symptoms have you had: (*Check all that apply*)
☐ any difficulty with bowel or bladder function
☐ fever/chills
☐ numbness in the genitals or anal area
☐ numbness
☐ any dizziness or fainting
☐ unexplained weakness
☐ unexplained weight change
☐ night pain/sweats
☐ malaise (vague feeling of bodily discomfort)
☐ problems with vision/hearing
☐ none of the above

10. What aggravates your symptoms (*Check all that apply*)
☐ sitting ☐ going to/rising from sitting
☐ walking ☐ up/down stairs
☐ standing ☐ squatting
☐ lying down ☐ sleeping
☐ looking up overhead ☐ sustained bending
☐ reaching overhead ☐ reaching in front of body
☐ reaching behind back ☐ reaching across body
☐ repetitive activity______________________________
☐ household activity______________________________
☐ recreation/sports including________________________
☐ coughing/sneezing ☐ taking a deep breath
☐ talking ☐ chewing ☐ yawning
☐ swallowing ☐ stress

11. What relieves your symptoms? (*Check all that apply*)
☐ nothing ☐ medication ☐ wearing splint/orthosis
☐ rest ☐ cold ☐ heat
☐ sitting ☐ standing ☐ walking
☐ stretching ☐ exercise ☐ massage
☐ lying down

HEALTH QUESTIONNAIRE

Medications:

Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, ect*):

____

____

____

____

____

Are you currently taking any of the following over the counter Medications?

- ☐ aspirin
- ☐ Advil/Motrin/Ibuprofen
- ☐ Tylenol
- ☐ corticosteroids
- ☐ antihistamines
- ☐ vitamins/mineral supplements

Occupational Information:

Occupation______________________________

- ☐ employed full time
- ☐ student
- ☐ employed part time
- ☐ retired
- ☐ self employed
- ☐ unemployed
- ☐ homemaker
- ☐ other____________

Are you currently seeking disability for this condition

☐ Yes ☐ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

☐ Yes ☐ No

Living Environment:

- ☐ live alone
- ☐ live with others
- ☐ home/apartment
- ☐ retirement complex (SNF/ICF)
- ☐ assisted living complex

- ☐ stairs(railing)
- ☐ elevator
- ☐ ramp
- ☐ stairs (no railing)
- ☐ uneven ground
- ☐ no stairs
- ☐ other__________________

General Health:

How would you rate your general health?

- ☐ Excellent
- ☐ Average
- ☐ Poor
- ☐ Good
- ☐ Fair

Previous Functional Level

- ☐ Independent in all activities (work,community,home,recreation)
- ☐ Independent in all self-care activities (bathing,toileting,dressing,etc.)
- ☐ Difficulty performing self-care activities
- ☐ Needed assistance with self-care activities
- ☐ Difficulty performing household chores
- ☐ Difficulty with activities in community outside of home

Do you exercise outside of normal daily activities?

- ☐ 5+days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wk
- ☐ occasionally
- ☐ zero

Exercise, sports/recreation consisting of______________________________

What is your general stress level?

☐ Low ☐ Medium ☐ High

Alcohol Intake

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status?

☐ Never ☐ Current ☐ Former smoker ☐ Occasional

If smoker how much?______________________

Are you seeing any health care providers other than the physical therapist for this current condition?

(*please list*)______________________________

Medical History:

Have you ever had/been diagnosed with any of the following conditions? (*Check all that apply*)

- ☐ No diseases/conditions
- ☐ Cancer
- ☐ Arthritis
- ☐ Depression
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Dental Problems
- ☐ Stroke
- ☐ Headaches/Migraines
- ☐ Hepatitis
- ☐ Heart Problems
- ☐ HIV or AIDS
- ☐ Pacemaker
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Muscle/Joint/Bone Problems
- ☐ Stomach Problems
- ☐ Circulation/Vestibular Problem

Surgical/Tests History:

☐ No surgeries

Type/Date	*Type/Date*
☐ Shoulder Surgery________	☐ Hip Surgery________
☐ Knee Surgery__________	☐ Joint Repl.________
☐ ACL reconst.__________	☐ Heart Surgery______
☐ Back Surgery__________	☐ Elbow Surgery______
☐ Ankle/Foot Surgery______	☐ Neck Surgery______

☐ Other______________________________

☐ Other______________________________

Have you had any of the following tests?

- ☐ None
- ☐ Bone Scan
- ☐ Vestibular
- ☐ x-rays
- ☐ Arthrogram
- ☐ CT Scan
- ☐ MRI
- ☐ Stress X-ray Test

Family History:

- ☐ No diseases or conditions
- ☐ Diabetes
- ☐ Alzheimer's
- ☐ Heart Disease
- ☐ Cancer
- ☐ Stroke/CVA
- ☐ Arthritis
- ☐ RA
- ☐ Asthma
- ☐ Musc/Skeletal Dis.
- ☐ Skin disorder
- ☐ Osteoporosis
- ☐ Mental disorder
- ☐ Other____________