Patient Information Form

Patient Information

Last Name: _____ First Name: _____ MI: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ Email: _____

Emergency Contact

Last Name: _____ First Name: _____

Relationship: _____ Phone: _____

Employer

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Problem

Problem Description: _____

Date of Injury: _____ Motor Vehicle Accident: Y N State Accident Occurred: _____

Referred By: _____ Last Physician Visit: ____/____/____

Latest Referral Information: _____

Latest Plan of Care: _____

Notes: _____

Primary Insurance

Insurance: _____ ID: _____ Group #: _____

Deductible: _____ Coinsurance: _____ Copay: _____ Max Benefit: _____

Secondary Insurance

Insurance: _____ ID: _____ Group #: _____

Deductible: _____ Coinsurance: _____ Copay: _____ Max Benefit: _____

Tertiary Insurance

Insurance: _____ ID: _____ Group #: _____

Deductible: _____ Coinsurance: _____ Copay: _____ Max Benefit: _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.

Signature: _____ Date: ____/____/____

Patient Acknowledgement and Consent

Financial Policy Your billing will be prepared and managed by MOTION PT group as a Hand Therapy Associates provider. All billing statements for services received at this location will come to you from Hand Therapy Associates. Please make all checks payable to Hand Therapy Associates.

PATIENT FINANCIAL RESPONSIBILITY: Hand Therapy Associates is contracted with many insurance companies. All bills for your outpatient rehabilitation therapy services will be submitted by Hand Therapy Associates directly to your insurance carrier. By signature below, you authorize payment of medical benefits directly to Hand Therapy Associates and understand you are responsible for payments of all services rendered in the event any third party does not pay. If you belong to an HMO/ Managed Care Organization that Hand Therapy Associates participates with, you agree to be responsible for securing necessary referrals and making direct payments as required by your plan. As a courtesy, MOTION PT Group will submit to insurance for physical, occupational and/or speech therapy authorizations. Medicare patients participating in the Telehealth program – please be advised that physical therapy is not a covered Medicare service as part of the Telehealth program. Patients will be responsible for payment at the time of service or will be billed for services in full at a later date. By signature below, you acknowledge understanding of responsibility for payment of all services rendered.

Agree: _____ (patient signature)

CO-PAYMENTS, DEDUCTIBLES and FEES: Hand Therapy Associates is legally and contractually required to comply with the payment policies set forth by each insurance plan. As a result, Hand Therapy Associates will not uniformly waive co-payments and/or deductibles. Copayments must be paid in full before each treatment session. If you choose to issue your co-payments on a weekly basis, payment is due prior to your first treatment session of the week. If you wish to cancel or reschedule an appointment, we require a minimum of 24-hour advance notice. Less than 24-hour notice may result in a $25 cancellation fee. If you have frequent cancellations or fail to keep two appointments without notice, you may be discharged from the program. Applicable cancellation fees may be charged to your patient account. If you are experiencing financial hardship, you may qualify for financial assistance with the cost of your services. Please ask to speak to a member of the Hand Therapy Associates Patient Accounts Department. In the event it becomes necessary to refer your account for collection, you will be held responsible for the attorney fees and collection costs.

Agree: _____ (patient signature)

CONSENT FOR TREATMENT AND CARE FOR ADULT PATIENT: By signature below, you agree and give consent to receive outpatient rehabilitation therapy services through Hand Therapy Associates and its contracted provider MOTION PT Group and as such consent to receive rehabilitative treatment as considered necessary and proper by the treating therapist(s) in treating my physical condition. No guarantees have been made regarding the projected outcome of care. I understand I have the opportunity and am encouraged to ask questions about my care and treatment.

Agree: _____ (patient signature)

TREATMENT OF MINOR: **By signature below, I** agree and give consent as either parent or legal guardian for my minor child who is under the age of 18 ("Minor") to receive outpatient rehabilitation therapy services through Hand Therapy Associates and its contracted provider MOTION PT Group and as such grant consent for Minor to receive rehabilitative treatment as considered necessary and proper by the treating therapist(s) in treating Minor's physical condition. No guarantees have been made regarding the projected outcome of care. I understand that as parent or legal guardian I have the opportunity and am encouraged to ask questions about Minor's care and treatment. I further understand that as parent or legal guardian of Minor, I must accompany Minor to his/her Initial Evaluation. I further understand that as parent or legal guardian of a Minor under the age of 12, I must be present during all care or treatment rendered to Minor. As parent or legal guardian, I am not required to attend follow up treatment sessions if Minor is 12 years or older, provided that the *"Consent to Treat a Minor"* document has been completed.

Agree: _____ (patient or legal guardian signature)

DISCLOSURE TO INDIVIDUALS: I acknowledge I have been offered a copy of Hand Therapy Associates's HIPAA Notice of Privacy Practices. I authorize Hand Therapy Associates to use and/ or disclose my Protected Health information ("PHI") to carry out and arrange for my treatment, seek and receive payments for my treatments, and carry out business operations of the office in accordance with the permitted disclosures under HIPAA. I give permission to Hand Therapy Associates and its contracted provider MOTION PT Group and/or their authorized representatives to communicate medical information to me via any or all of the following methods as checked below:

☐ Voicemail: Phone #_____ ☐ Fax: #_____

☐ Email: Email address:_____ ☐ Writing

I give permission to Hand Therapy Associates and MOTION PT Group providers and/or their authorized representatives to discuss my personal healthcare information only with the following individual(s) whom I have listed below:

Name:	Relationship to Patient
1. _____	_____
2. _____	_____

Agree: _____ (patient signature)

MOTOR VEHICLE/NO FAULT/WORKERS'COMPENSATION: If I have been involved in a motor vehicle accident or a worker's compensation injury, I agree it is my obligation to disclose that to Hand Therapy Associates and its contracted provider MOTION PT Group. I understand and agree that I must complete and submit No Fault application to my carrier within 30 days of accident date (or other period as determined by my carrier or applicable law) and comply with any Independent Medical Examination (IME) requests. If I fail to do so, I understand and agree that I will be held responsible for all payments until the time of settlement, judgment, or payment by attorney or the automobile insurance company. If I sustained an injury on the job and are receiving Physical, Occupational and/or Speech Therapy under Worker's Compensation I understand and agree that I will comply with all requests set forth by Worker's Compensation laws and carriers

Agree: _____ (patient signature)

I have read this Patient Acknowledgement and Consent. I hereby agree to receive treatment and physical, occupational and/or speech therapy services in accordance with the above stated terms.

Patient Signature:_____Printed Name:_____Date: _____

Patient Cancellation/Missed Appointment Policy and Acknowledgement

MOTION strives to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and improvement of your physical abilities is something everyone in our clinic takes seriously.

Because we care about you and your progress in therapy, we emphasize the importance of patient commitment to the care you receive at MOTION owned, operated and/or managed clinics. Scheduling is based on numerous factors, including patient need, staff availability and physician orders. Your dedication to the recommended number of treatments is a vital component of your progress; therefore, we have certain requirements that should be followed in order to ensure optimum results.

We expect all patients to keep all scheduled appointments or to provide adequate 24 hour notice of intent to cancel and reschedule an appointment. If you need to cancel and reschedule an appointment, please provide us with greater than 24 hours' notice. To maintain your therapy schedule and ensure optimal results of your therapy, your make-up appointment should be the same week, preferably the day following your original appointment.

In cases of two occurrences of non-compliance with your scheduled visits, in accordance with applicable law, you will be charged a cancellation fee of Twenty Five Dollars ($25.00) which will be solely your responsibility (i.e. no third party will be charged a cancellation fee). Further, we reserve the right to discontinue your care with a reasonable amount of notice to you so that you may locate another therapist to continue your care or discontinue your privilege to schedule appointments in advance allowing only same day scheduling when available. We will also inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order should we follow that course.

PLEASE PROVIDE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR FOR RESCHEDULING AN APPOINTMENT. APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A $25.00 CANCELLATION FEE.

We value your patronage and strive to accomplish optimal results and success for you

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I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO ADHERE TO THE POLICY

Signature _____ Date _____

Printed Name _____

MEDICATION FORM

Patient's Name _____ **Date** _____

Please fill out required information regarding **ALL MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS, AND DIETARY / HERBAL SUPPLEMENTS** below **COMPLETELY**:

❑ I am currently **NOT** taking any of the above

MEDICATION **Prescription, Over the Counter, Vitamins, Herbals, Dietary Supplements**	**DOSAGE**	**FREQUENCY (times per day)**	**ROUTE** **(Oral, Injection, Transdermal, Inhale)** **Patients with Medicare MUST complete**	**REASON FOR MEDICATION**

I acknowledge I have reviewed the above listed information noted with patient

Therapist Signature _____ Date _____

Patient's Name _____ **Date** _____

MEDICAL HISTORY	YES	NO	ONSET DATE
Anemia			
Chest pain / heart attach / coronary artery disease			
High Blood Pressure			
Arthritis			
Pulmonary Condition			
Cancer			
Diabetes			
Abnormal Bleeding / Clotting			
Vision Deficits			
Depression / Anxiety			
Hearing Problems			
Kidney Disease			
Osteoporosis			
Falls			
Fractures			
Seizures			
Incontinence			
Thyroid Disorder			
Strokes / TIA			
Active Infection			
Other Neurologic Disorder			
Loss of Consciousness			
MRSA / VRE / C-Diff			
Headaches			
Skin Disorder			
Other			

Surgical History: List and Date

1 _____ 2 _____ 3 _____

I acknowledge I have reviewed the above listed information noted with patient

Therapist Signature _____ Date _____

Patient's Name _____ **Date** _____

PRIMARY MEDICAL CONDITION REQUIRING REHABILITATION

_____

ALLERGIES

☐ Yes ☐ No Allergic Reaction _____

SPECIAL TESTS PERFORMED

X-Ray	CAT Scan	MRI	Bone Scan	Other
Date & Result				

Have you ever had therapy for this problem? ☐ Yes ☐ No

Are you under anyone else's care for this problem now? ☐ Yes ☐ No

Have you had Physical Therapy before? ☐ Yes ☐ No

If yes, please explain _____

SOCIAL HISTORY

Home Status

Current living arrangement Live Alone ☐ Live w. Partner ☐

Live w. Family/Friend ☐ Other _____

Do you live with children 18 years or younger? ☐ Yes ☐ No

Do you have stairs going into your home / building? (If yes, how many?) ☐ Yes ___ ☐ No

Smoking History

☐ Current Smoker # Packs per day _____

☐ Former Smoker Quit Date ___/___

☐ Never Smoked

Use of Alcohol

☐ Social ☐ Weekly ☐ 1 – 2 per day ☐ 2+ per day

Are you currently working? ☐ Yes ☐ No

Occupation _____

Cultural Needs

Do you require an interpreter? (Bilingual patients may need an interpreter) ☐ Yes ☐ No

What is the primary language spoken at home? _____

Are there any cultural / religious practices that you would like us to be aware of before treatment? ☐ Yes ☐ No

If yes, please explain _____

Patient's Name _____ **Date** _____

PAIN

Do you have persistent or frequent pain? ☐ Yes ☐ No

If **YES**, complete below

Location on body _____

Does pain affect your daily activities ☐ Yes ☐ No

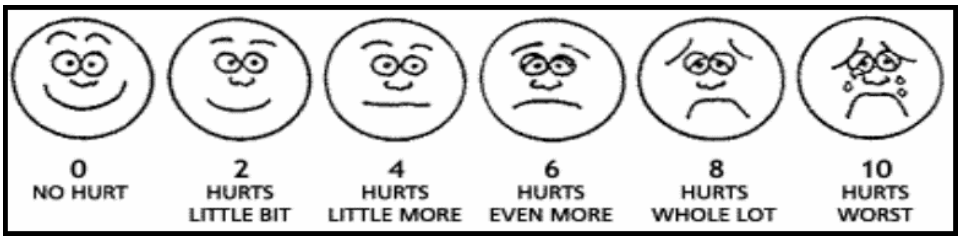
Does pain awake you at night? ☐ Yes ☐ No

Circle One

0	1	2	3	4	5	6	7	8	9	10

Mild **Moderate** **Severe**

NO PAIN



WORST PAIN

Do you have durable medical equipment? (i.e. walker, wheelchair, etc.) _____

What exercises of sports do you participate in? _____

List your three major **FUNCTIONAL** difficulties / problems
(i.e. Self-Care, Household Chores, Changing Positions, Shopping, Transportating, Walking, Work)

1. _____
2. _____
3. _____

List your three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____

I acknowledge I have reviewed the above listed information noted with patient

Clinician Signature _____ Date _____