MOTION SPORTS MEDICINE

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 authorize medical benefits to be paid directly to ProHEALTH.
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 Sports Medicine as a ProHEALTH provider. All billing statements for services received at this location will come to you from ProHEALTH. Please make all checks payable to ProHEALTH.

PATIENT FINANCIAL RESPONSIBILITY: ProHEALTH is contracted with many insurance companies. All bills for your outpatient rehabilitation therapy services will be submitted by ProHEALTH directly to your insurance carrier. By signature below, you authorize payment of medical benefits directly to ProHEALTH 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 ProHEALTH participates with, you agree to be responsible for securing necessary referrals and making direct payments as required by your plan. As a courtesy, MOTION Sports Medicine 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: ProHEALTH is legally and contractually required to comply with the payment policies set forth by each insurance plan. As a result, ProHEALTH 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 ProHEALTH 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 ProHEALTH and its contracted provider MOTION Sports Medicine 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 ProHEALTH and its contracted provider MOTION Sports Medicine 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 ProHEALTH's HIPAA Notice of Privacy Practices. I authorize ProHEALTH 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 ProHEALTH and its contracted provider MOTION Sports Medicine 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 ProHEALTH and MOTION Sports Medicine 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 workers compensation injury, I agree it is my obligation to disclose that to ProHEALTH and its contracted provider MOTION Sports Medicine. 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 _____

GENERAL MEDICINE PEDIATRIC INTAKE FORM

PATIENT INFORMATION

Patient Name: _____

Parent / Guardian Name: _____ Relationship to Patient: _____

Pediatrician: _____ Referring MD: _____

Birth History

Date of Delivery: ___/___/___ Age: _____ Type of Delivery: ☐ Vaginal ☐ Caesarean

Complications? ☐ Yes ☐ No

If yes, please explain _____

Premature Birth? ☐ Yes ☐ No

If yes, please explain _____

NICU? ☐ Yes ☐ No

If yes, please explain _____

MEDICAL HISTORY

Primary Medical Condition Requiring Rehabilitation When did the problem begin ___/___

Briefly describe the reason for your visit

Are you/your child under the care of another Physical / Occupational / Speech Therapist for this condition? ☐ Yes ☐ No

Please list any significant medical / surgical history

Please list any hospitalizations

Have you/your child received Physical / Occupational / Speech Therapy

☐ for this condition in the past (if yes, explain below)	☐ for a previous condition (if yes, explain below)

Have you/your child seen a specialist (physician, psychologist, special education teacher, etc.)

☐ for this condition in the past (if yes, explain below)	☐ for a previous condition (if yes, explain below)

Therapist Signature: _____

Date: _____

MOTION PT GROUP

Please indicate approximate age of onset or date for the following:

Illness / Diagnosis	~ Age of Onset / Date	Illness / Diagnosis	~ Age of Onset / Date
Allergies		Feeding Tube	
Apraxia of Speech		German Measles	
Asthma		Headaches	
ADHD		Hearing Loss	
Autism		High Fever	
Cerebral Palsy		Influenza	
Chicken Pox		Mastoiditis	
Cleft Palate / Lip		Measles	
Colds		Meningitis	
Convulsions		Mumps	
Croup		Pneumonia	
Dizziness		PE Tubes	
Down Syndrome		Reflux	
Draining Ear		Sinusitis	
Dyslexia		Stuttering	
Ear Infections		Tinnitus	
Encephalitis		Tonsillitis	
Epilepsy / Seizures		Vision Problems	

Other(s): _____

Genetic Abnormalities: _____

Learning Disabilities: _____

Is there a history of speech, language or hearing impairments in your family? (if yes, describe below) ☐ Yes ☐ No

_____

Does your child use any of the following devices? If yes, please note device type and wearing schedule below

☐ Orthotics	
☐ Braces	
☐ Splints	
☐ Augmentative and Alternative Communication Devices	

MEDICATION INFORMATION

Please list ALL medication, vitamins, herbals and dietary supplements you/your child are currently taking

MEDICATION (prescription, over-the-counter, vitamins, herbals, dietary supplements)	DOSAGE	FREQUENCY (times per day)	ROUTE (oral, injection, transdermal, inhale)	REASON FOR MEDICATION

Therapist Signature: _____

Date: _____

MOTION PT GROUP

SPECIAL TEST		
Test Performed	Date	Result
X-Ray		
CAT Scan		
MRI		
Bone Scan		
Video Fluoroscopic Swallow Study (VFSS)		
Fiberoptic Endoscopic Evaluation of Swallowing (FEES)		
Other: _____		

PAIN

Do you/your child have persistent or frequent pain? (if yes, complete below) ☐ Yes ☐ No

Location on body _____

_____

_____

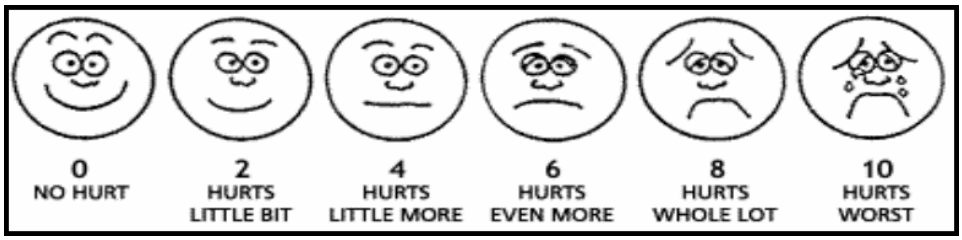
Pain at WORST

Circle One

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

NO PAIN



WORST PAIN

_____

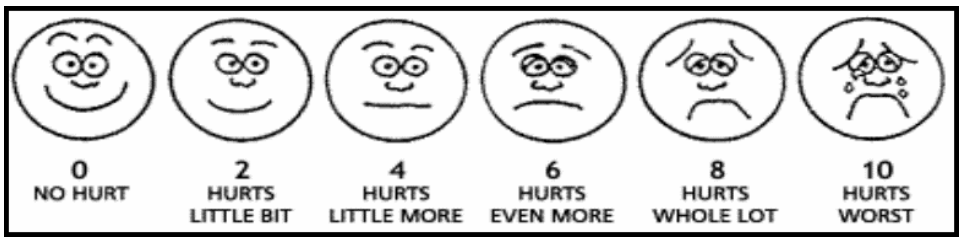
Pain at BEST

Circle One

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

NO PAIN



WORST PAIN

_____

Therapist Signature: _____

Date: _____

MOTION PT GROUP

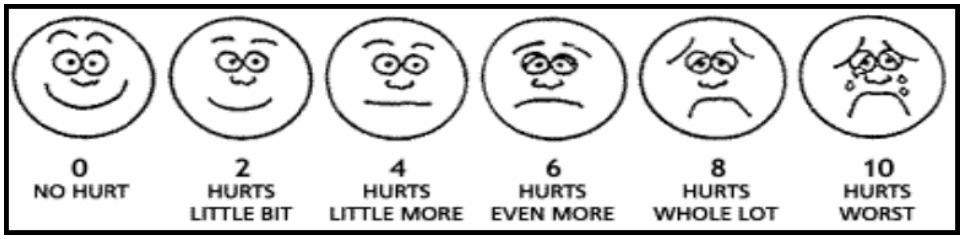
Pain on AVERAGE

Circle One

0	1	2	3	4	5	6	7	8	9	10

Mild **Moderate** **Severe**

NO PAIN



WORST PAIN

Does pain awake you/your child at night? ☐ Yes ☐ No

Does pain affect your/your child's daily activities? (if yes, complete below) ☐ Yes ☐ No

Please circle all symptoms that apply

Aching	Burning	Numbness
Tingling	Throbbing	Spasms
Tightness	Dull Pain	Sharp Pain

Other: _____

ALLERGIES

Please indicate your/your child's allergies and allergic reactions if applicable

Allergic to	Reaction
☐ Tape	
☐ Latex	
☐ Food (specify)	
☐ Other:	

SOCIAL HISTORY

Home Status

Child lives with Both Parents ☐ Mother ☐ Grandparents ☐ Father ☐ Other: _____

Do you/your child live with siblings and/or other children? (if yes, complete below) ☐ Yes ☐ No

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

What is the primary language spoken at home? _____

If multilingual, please note additional languages: _____

Are there steps to enter your/your child's building / home or within the home? (if yes, complete below) ☐ Yes ☐ No

Number of steps **to enter** _____ Number of steps **within** _____

Therapist Signature: _____

Date: _____

MOTION PT GROUP

List your/your child's three major **FUNCTIONAL** difficulties / problems
(e.g. self-care, household chores, changing positions, shopping, transportation, walking, communicates wants & needs)

1. _____
2. _____
3. _____

List your/your child's three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your/your child's **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____

Therapist Signature: _____

Date: _____