PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ M _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

D.O.B.: _____ **Gender:** male / female **Pronoun (optional):** he / she / they / ze / ey

Phone: _____ **Email:** _____

EMERGENCY CONTACT

Last Name: _____ **First Name:** _____

Relationship: _____ **Phone:** _____

EMPLOYER INFORMATION

Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

PRIMARY CONCERN

Description: _____

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

Referred By: _____ **Last MD Visit:** _____

Notes: _____

PRIMARY INSURANCE

Insurance: _____

ID: _____ **Group #:** _____ **Copay:** _____

Deductible: _____ **Coinsurance** _____ **Max Benefit** _____

SECONDARY INSURANCE

Insurance: _____

ID: _____ **Group #:** _____ **Copay:** _____

Deductible: _____ **Coinsurance** _____ **Max Benefit** _____

I authorize release of information requested by my insurance plan for payment.
I authorize medical benefits to be paid directly to Cypress Creek Therapy.
I understand that I am financially responsible for any balance due.

Signature _____ **Date:** _____

PATIENT ACKNOWLEDGEMENT & CONSENT

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

PATIENT FINANCIAL RESPONSIBILITY: Cypress Creek Therapy is contracted with many insurance companies. All bills for your outpatient rehabilitation therapy services will be submitted by Cypress Creek Therapy directly to your insurance carrier. By signature below, you authorize payment of medical benefits directly to Cypress Creek Therapy 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 Cypress Creek Therapy 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. 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 / legal guardian signature)

CO-PAYMENTS, DEDUCTIBLES and FEES: Cypress Creek Therapy is legally and contractually required to comply with the payment policies set forth by each insurance plan. As a result, Cypress Creek Therapy 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 $50 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 Cypress Creek Therapy 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 / legal guardian signature)

CONSENT FOR TREATMENT AND CARE FOR ADULT PATIENT: By signature below, you agree and give consent to receive outpatient rehabilitation therapy services through Cypress Creek Therapy 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 / legal guardian 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 Cypress Creek Therapy 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 / legal guardian 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 Cypress Creek Therapy 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 / legal guardian signature)

PATIENT ACKNOWLEDGEMENT & CONSENT

DISCLOSURE TO INDIVIDUALS: I acknowledge I have been offered a copy of Cypress Creek Therapy's HIPAA Notice of Privacy Practices. I authorize Cypress Creek Therapy 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 Cypress Creek Therapy 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 _____ ☐ Writing

I give permission to Cypress Creek Therapy 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 / legal guardian 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: _____

CANCELLATION / MISSED APPOINTMENT POLICY & 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 treatment(s) 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 hour 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 no-compliance with your scheduled visits, in accordance with applicable law, you will be charged a cancellation fee of Fifty Dollars ($50.00) which will be solely your responsibility (i.e. no third part will be charged a cancellation fee). Further, we reserve the right to discontinue your care with a reasonable amount of notice to out 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 following that course.

PLEASE PROVIDE AT LEASE 24 HOURS NOTICE FOR CANCELLATION OR FOR RESCHEDULING AND APPOINTMENT. APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A $50.00 CANCELLATION FEE

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

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

Signature _____ Date _____

Printed Name _____

Patient Name: _____ Date: _____

Therapist Sig: _____

INTAKE FORM
GENERAL MEDICINE

MEDICATION INFORMATION

Please complete required information regarding ALL medications, vitamins, herbals or dietary supplements you are currently taking.

☐ I am currently **NOT** taking any Medication, Prescription, Over the Counter, Vitamins, Herbals, or Dietary Supplements

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

Patient Name: _____ **Date:** _____

Therapist Sig: _____

INTAKE FORM
GENERAL MEDICINE

MEDICAL HISTORY

	YES	NO	ONSET DATE
COVID-19	☐	☐	
Anemia	☐	☐	
Chest pain / heart attack / 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	☐	☐	

Please list and date any significant medical / surgical history

Patient Name: _____ **Date:** _____

Therapist Sig: _____

INTAKE FORM
GENERAL MEDICINE

PRIMARY MEDICAL CONCERN REQUIRING REHABILITATION

_____

ALLERGIES

☐ Yes ☐ No Allergic Reaction _____

SPECIAL TEST

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 or Occupational Therapy before? ☐ Yes ☐ No

If yes, please explain _____

SOCIAL HISTORY

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 _____

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 steps?) _____ ☐ Yes ☐ No

Have you had a fall in the last 12 months? ☐ Yes ☐ No

Do you have a fear of falling? ☐ 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

Patient Name: _____ **Date:** _____

Therapist Sig: _____

INTAKE FORM
GENERAL MEDICINE

Occupation

Are you currently working? (If yes, list job title) _____ ☐ Yes ☐ No

PAIN

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

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**

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
(e.g. self-care, household chores, changing positions, shopping, transportation, walking, communicates wants & needs)

1. _____
2. _____
3. _____

List your three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____