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**_____

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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.

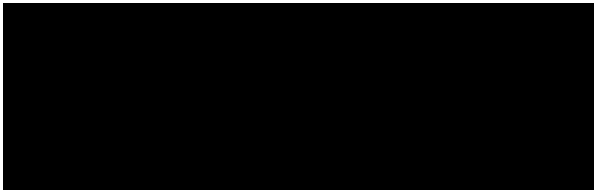
Returned Checks*:* A $35.00 fee will be charged for each check returned to us unpaid by your bank.

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)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

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

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

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

❑ cancer	❑ diabetes	❑ tuberculosis
❑ heart problems	❑ stroke	❑ thyroid problems
❑ high blood pressure	❑ depression	❑ 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) ____________________________

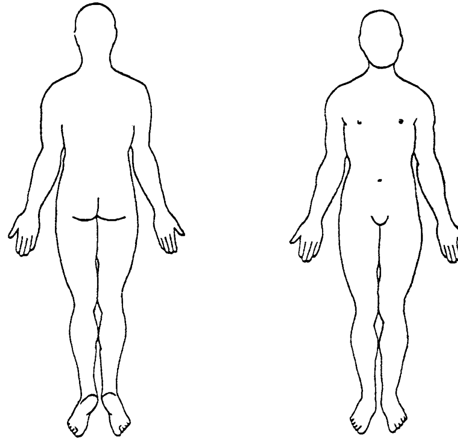
Please list special tests performed for this problem (x-ray, MRI, labs, etc) ___________________________

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**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

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

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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

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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 ____________________