Patient Information

Patient Name:____
First Last Middle Initial

Preferred Name: ______________________________ Date of Birth: __________________
(MM/DD/YYYY)

Mailing Address: ____
Street or PO Box City State Zip

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ E-Mail: ______________________________

Appointment Reminder Preference: ◻ Text ◻ Email ◻ Voice (Home) ◻ Voice (Cell) ◻ Voice (Work)

Date of Injury/Onset: ______________ Have you had any Physical Therapy this year?: ◻ Yes ◻ No

How did you hear about us?/Who may we thank for referring you? ______________________________

Insurance Information

Primary Insurance Plan: _____________________________________ Work/Auto: ◻ Yes ◻ No

ID/Policy#: ______________________ Group#: ______________________

Secondary Insurance Plan: ____

ID/Policy#: ______________________ Group#: ______________________

Emergency Contact Information

Name:______________________________________ Relationship to Patient:_____________

Phone:___________________ Address:____

Patient's Authorization to Release Medical Records

I authorize Healing Motion Physical Therapy to request/send/release medical records that are in relation to the purpose of my physical therapy visit. I understand there may be a fee of $30.00 for a full records request.

__________________________________ ____________________

Patient or Authorized Representative Signature Date

HEALING MOTION
PHYSICAL THERAPY

Patient Acknowledgement & Consent

I, ____, understand and agree that Healing

Motion Physical Therapy may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among other health care providers for my care and treatment;
- Determine my eligibility for health insurance and submit bills, claims, and other related information to my insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various administrative and business functions that support efforts to provide me with, and be reimbursed for, cost effective health care.

I understand that my health information may include information both created and received by Healing Motion Physical Therapy, and may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I also understand that I have the right to receive and review a written description of how Healing Motion Physical Therapy will handle health information about me. This written description is known as Notice of Privacy Practices and describes the uses and disclosures of health information made and the information pracrices followed by the staff of Healing Motion Physical Therapy, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of the most recent version of the Privacy Practices in effect is available for review from the office receptionist.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I also understand that Healing Motion Physical Therapy is not required by law to agree to such requests.

By signing below, I agree that I have received and understand the information above.

______________________________________ ______________________

Patient or Authorized Representative Signature Date

Welcome to Healing Motion Physical Therapy!
To help you understand our policies, please read and initial the following guidelines.

Appointments
Attendance at all scheduled appointments is important. Our appointments are on a 45-minute basis. If you are late for your appointment, your therapist may feel it necessary to do only a portion of your treatment or reschedule for another day. If a scheduling conflict occurs, please call us at 541-929-2255 as soon as possible. We may be able to use your time for another patient and reschedule you for a more convenient time.

Appointment Fee Policies
I understand that the responsibility for attending appointments that are scheduled in mine. A reminder card will be given when the appointment is scheduled. If a no show, late arrival, or late cancellation occurs, you will be billed at the following rate. **Please initial next to each fee.**

______NO SHOW: If you do not arrive to a scheduled appointment you will be billed **$50**.

______LATE CANCELLATION: Due to scheduling, we ask for at least 24-hours' notice for cancellations. If you call to cancel with less than 24-hours' notice, you will be billed **$40**.

______LATE ARRIVAL: If you arrive more than 15-minutes late to your scheduled appointment, you will be billed **$30** to recoup expenses.

Co-Payments
Please be aware of your insurance benefits and be prepared to pay any co-payments you may have at each appointment.

Assignment of Insurance Benefits
By signing below, you assign and authorize payments to be made directly to Healing Motion Physical Therapy, Inc. the insurance benefits which would otherwise be payable to you for physical therapy expenses. A photocopy of this assignment and authorization is considered as valid and effective as the original.

Notice Regarding Insurance Benefits
You understand that you are responsible for charges incurred with Healing Motion Physical Therapy which are not covered through your insurance. As a service to you, we will complete and submit your insurance claim. All fess and expenses incurred by you in this clinic, not compensated by your insurance company are solely your responsibility. Regardless of any insurance claims, full payment is due in less that 60 days.

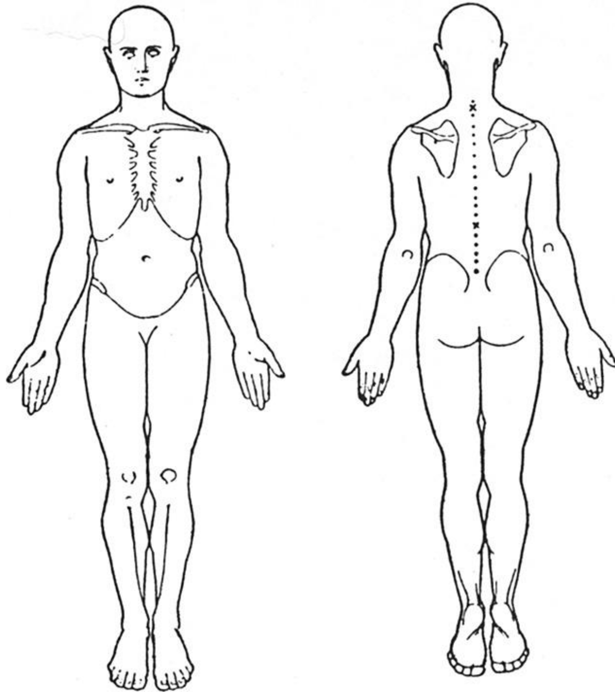
______________________________ ____________________

Patient or Authorized Representative Signature Date

HEALING MOTION PHYSICAL THERAPY

Name: ________________________

Please shade in the location of your symptoms



Social History

Marital Status ______________

Occupation ______________

Do you smoke? ◻ Yes ◻ No

Did you used to smoke? ◻ Yes ◻ No

Do you chew tobacco? ◻ Yes ◻ No

Do you drink alcohol? ◻ Yes ◻ No

Frequency: ______________

Do you exercise? ◻ Yes ◻ No

Frequency: ______________

Surgical History

Please list any recent and relevant surgeries (type and date)

____

____

____

____

____

Medication List

Please attach your current medication/supplement list. Include medication/supplement name, dosage, frequency, and how it is administered (i.e. oral, injection, topical, etc.). If you did not bring your list, complete the following:

Name	Dosage	Frequency	Method of Administration

Medical History

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

◻ Yes ◻ No

During the past month, have you often been bothered by little interest or pleasure in doing things?

◻ Yes ◻ No

HEALING MOTION
PHYSICAL THERAPY

Cardiovascular	Past	Current	Explain
Heart disease			
High blood pressure			
High cholesterol			
Palpitations			
Chest pain on exertion			
Shortness of breath			
Swelling of arms and/or legs			
Family history cardiovascular disease			
Anemia			
Blood transfusion			
Stroke/TIA			
Clotting disorder			
Seizures			
Blood clots			
Respiratory	**Past**	**Current**	**Explain**
Wheezing			
Prolonged cough			
Sputum			
Pneumonia			
Tuberculosis			
COPD			
Emphysema			
Asthma			
Pulmonary embolism			
Gastrointestinal	**Past**	**Current**	**Explain**
Heartburn			
Nausea			
Vomiting			
Constipation			
Diarrhea			
Change in color of stools			
Rectal bleeding			
Abdominal pain			
Liver problems			
Gallbladder problems			
Musculoskeletal & Arthritides	**Past**	**Current**	**Explain**
Osteopenia			
Osteoporosis			
Fracture			
Long-term steroid use			
Rheumatoid Arthritis			
Systemic Lupus Erythematosus			
Gout			
Osteomyelitis			
Psoriatic Arthritis			
Ankylosing Spondylitis			

Neurological	Past	Current	Explain
Numbness/tingling both hands/feet			
Unexplained difficulty walking			
Double vision			
Difficulty speaking			
Difficulty swallowing			
Drop attack			
Involuntary eye movement/dizziness			
Numbness			
Change in bowel/bladder function			
Change in sensation in bowel/bladder region			
Migraines			
Dizziness/vertigo			
Urological & Reproductive	**Past**	**Current**	**Explain**
Painful urination			
Blood in urine			
Incontinence			
Frequent urination			
Urinary urgency			
Difficulty initiating urination			
Severe menstrual cramps			
Postmenopausal bleeding			
Painful intercourse			
Urinary infection			
Irregular vaginal discharge			
STD			
HIV/AIDs			
Decreased force of urinary flow			
Impotence			
Urethral discharge			
Pregnancy			
Other Conditions	**Past**	**Current**	**Explain**
Diabetes			
Kidney disease			
Thyroid problems			
Night pain			
Unexplained weight loss			
Cancer			
Family history cancer			
Fever			
Chills			
Sweats			
Extreme fatigue			
Lightheadedness/Fainting			
Recent infection			
Drug/IV use			
Anxiety/panic attacks			
Allergies (tape, etc.)			
Other			