movement systems
physical therapy

PATIENT REGISTRATION

Patient

First Name ______________________ MI ___ Last Name _________________________ DOB ____/____/_____

Address____ City _______________ State _____ Zip ____________

Primary Phone (   ) _______________ Secondary Phone (   ) ________________ Gender ☐ Male ☐ Female

Email ____
(for clinic use only, not for marketing or third party use)

Emergency Contact

Name ______________________________ Relationship ____________________ Phone (   ) ____________

Problem

Injury/Body Part ____

Referring Provider / Clinic ___________________________________ Last MD Visit ____/____/____

Primary Insurance Information | Secondary Insurance Information

Primary Insurance Information	Secondary Insurance Information	
Insurance ____________________	Insurance_____________________	☐ SELF PAY
ID No. _______________________	ID No. _______________________	I choose to receive and to pay for the therapy services out of pocket. I understand I will receive a 20% discount off the FULL AMOUNT of the visit total. Paid at time of service.
Group No. ____________________	Group No. ____________________	

Please present your Insurance Card(s) and a Photo ID to the front desk staff.

****MEDICARE PATIENTS: As a non-assigned Medicare Provider, we ask for payment at time of service. Please refer to our Medicare Payment Policy*****

Claim Information (for Work or Auto Injuries Only)

☐ W-Comp (L&I) Claim ☐ MVA/PIP Claim No. __________________ Date of Injury ____/____/____

Claim Manager's Name ____ Phone (_____) ____________

Acknowledgement

Patient's or authorized person's signature:

- **I authorize the release of any medical records or other information necessary to process claims.**
- **I authorize payment of medical benefits to MOVEMENT SYSTEMS PHYSICAL THERAPY, P.S.**
- **I am financially responsible for any balance due on all covered or non-covered services.**

Signature ____ **Date** __________
(Parent / Guardian if patient is a minor)

FINANCIAL POLICY

Standard Insurance Policy:

- Coverage depends upon your insurance company and the specific plan you have chosen.
- You may need a current prescription, referral, or authorization for physical therapy services based on your insurance plan.
- Co-pays are due at the time of service.
- Benefit details are not a guarantee of payment.

Pre-Authorization Policy:

- If your plan requires pre-authorization, MSPT will complete and submit all required documents necessary.
- Authorizations are based on your insurances medical necessity review not on plan benefit limits.
- If your authorization is "pending" you may still choose to be seen to avoid a delay in care, however you will be accepting the financial responsibility should the authorization be denied.

Medicare Policy:

- MSPT is a "non-assigned" provider with Medicare.
- We ask that our Medicare patients pay in full at the time of service. You will only be charged 115% of the Medicare allowable per Medicare guidelines.
- Medicare will directly reimburse you the Medicare allowable portion, less your 20% co-payment and annual deductible.
- If you are seeking treatment due to an automobile accident, **you are required to notify Medicare**.
- **You MUST be discharged from any home health care services or agency prior to initiating outpatient physical therapy.** Medicare will not pay for both home health and outpatient care simultaneously.

Auto PIP / Third Party:

- We do not accept third-party or accident settlement liens. If you do not have a direct PIP Claim you can choose to submit your personal health insurance or pay **at the time of service** at the Self-Pay rate described below.

Self-Pay Policy:

- For patients without insurance coverage, or for those patients that have exceeded insurance benefits, a 20% discount is available for full payment **at the time of service**.

Paying Your Bill:

- You will receive a monthly statement in the mail for any non-covered or unpaid balances on your account.
- All unpaid balances that exceed 120 days will be assigned to a third party collection agency.
- Payment plans due to financial hardship will be considered upon special request.
- A fee of $25 will be charged for any check returned by the bank for Non-Sufficient Funds.

I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.

Signature ______________________________________ **Date** _________________

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CANCELLATION POLICY

Patients are seen, at Movement Systems Physical Therapy, by appointment only. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments in four to six week intervals.

In the event you need to cancel an appointment, we require at least **24 hours notice**. Your appointment time is very important to us. If we do not get at least 24 hours notice of your cancellation, or you do not arrive for your scheduled appointment (no show) you will be accessed a $50 fee.

We realize that emergencies do occur – late cancellation due to illness or family emergency is **excluded** from this policy.

I have read and understood the above policy.

Signature ____ Date ______________

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of Movement Systems Physical Therapy's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of *Notice of Privacy Practices*. I understand the Movement Systems Physical Therapy has the right to change the *Notice of Privacy Practices* and that I may contact this office at the above address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that Movement Systems Physical Therapy is not required to agree to my requested restrictions, *but if you do agree* then you are bound to abide by such restrictions.

Signature: _______________________________________ Date: _________________

I give permission for the following individual(s) to request treatment or account information:

____

____

INITIAL EVALUATION INTAKE FORM

____
Last Name
____
First Name

Date of Birth: ☐☐ ☐☐ ☐☐☐☐
Month Day Year
Sex: ☐ male ☐ female
Are you: ☐ Right-handed ☐ Left handed
Who referred you to us? ________________________

SOCIAL HISTORY

Cultural / Religious: Any customs or religious beliefs or wishes that might affect care?

____

With whom do you live?
☐ Alone
☐ Spouse only
☐ Spouse and children: # Children: __________
☐ Children only: # Children: ________
☐ Other relatives (not spouse or children)
☐ Group setting
☐ Personal care attendant
☐ Other:
☐ Ages of children living at home: ___, ___, ___, ___

Employment / Work / (Job / School / Play)
☐ Working full-time outside of home ☐ Working part-time outside of home
☐ Working full-time from home ☐ Working part-time from home
☐ Homemaker ☐ Student
☐ Retired ☐ Unemployed
☐ Occupation:

____

SOCIAL/HEALTH HABITS

How much caffeinated coffee or caffeine containing beverages do you drink per day? __________
Smoking
Currently smoke tobacco?
☐ No ☐ Yes
☐ Cigarettes/Cigars: # packs per day __________
Smoked in the past? ☐ No ☐ Yes
Year quit: ☐☐☐☐
Alcohol
How many days per week do you drink alcoholic beverages, on average? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
How many drinks do you have, on an average per day?
☐ 1 ☐ 2 ☐ 3

Exercise
Do you exercise? ☐ No ☐ Yes
Describe the exercise(s):
____
____

On average, how many days per week do you exercise or do physical activity? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
How many minutes, on an average day?_______

LIVING ENVIRONMENT

Does your home have:	**Do you use:**
☐ Stairs, no railing	☐ Cane
☐ Stairs, railing	☐ Walker
☐ Ramps	☐ Manual wheelchair
☐ Elevator	☐ Motorized WC
☐ Uneven terrain	☐ Glasses, hearing aides

☐ Any other obstacles:________________________
Where do you live?(home/condo/apt/other)
____

GENERAL HEALTH/EMOTIONAL STATUS

Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Have you had any major life changes during the past year? (eg., new baby, job change, death of a family member)
☐Yes ☐No 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 Do you ever feel unsafe or has anyone hit you or tried to injure you in any way?

FUNCTIONAL STATUS/ACTIVITY LEVEL

(check all that apply)
☐ Difficulty with locomotion/movement
☐ Bed mobility ☐ Transfers(bed to chair/bed to commode)
☐ Gait (walking)
☐ on level ☐ on ramps
☐ on stairs ☐ on uneven terrain
☐ Difficulty with self-care (bathing, dressing, toileting)
☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

☐ Difficulty with community and work activities
☐ work ☐ school ☐ recreation / play

MEDICAL / SURGICAL HISTORY

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe, and include dates:
Month Year
__________________________ ☐☐ ☐☐☐☐
__________________________ ☐☐ ☐☐☐☐
__________________________ ☐☐ ☐☐☐☐

Please check if you have or had any of the following

☐ Allergies	☐ Diabetes	☐ Muscular Dystrophy
☐ Anemia	☐ Dizzy Spells	☐ Osteoporosis
☐ Anxiety	☐ Emphysema/ Bronchitis	☐ Parkinson's
☐ Arthritis	☐ Fractures/ Broken Bones	☐ Repeated Infections
☐ Asthma	☐ Gallbladder	☐ Rheumatoid

	Problems	Arthritis
☐ Blood Disorders/ Problems	☐ Head Injury/ Concussion	☐ Seizures/ Epilepsy
☐ Cancer	☐ Hepatitis	☐ Skin Diseases
☐ Cardiac (Heart) conditions	☐ High Blood Pressure	☐ Speech Problems
☐ Cardiac Pacemaker	☐ Incontinence	☐ Strokes
☐ Chemical Dependency	☐ Kidney Problems	☐ Thyroid Disease
☐ Circulatory /Vascular Problems	☐ Low Blood Sugar/ Hypoglycemia	☐ Tuberculosis
☐ Currently Pregnant	☐ Lung Problems	☐ Ulcers/ Stomach Problems
☐ Depression	☐ Metal Implants	☐ Vision Problems
☐Developmental or Growth Problems	☐ Multiple Sclerosis	☐ Other

Within the past year, have you had any of the following symptoms? (Check all that apply)

☐ Chest pain
☐ Heart palpitations
☐ Cough
☐ Shortness of breath
☐ Dizziness or blackouts
☐ Coordination problems
☐ Weakness in arms or legs
☐ Loss of balance
☐ Difficulty walking
☐ Joint pain or swelling
☐ Pain at night
☐ Difficulty sleeping
☐ Loss of appetite
☐ Nausea / vomiting
☐ Bowel problems
☐ Weight loss/gain
☐ Urinary problems
☐ Fever/chills
☐ Headaches
☐ Hearing problems
☐ Vision problems
☐ Other: ___________

For men only: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

For women only: Have you been diagnosed with:
☐ Pelvic inflammatory disease ☐ Endometriosis
☐ Trouble with your period
☐ Complicated pregnancies or deliveries
☐ Other gynecological or obstetrical difficulties
If yes, please describe: _________________________

Are you seeing anyone else for THIS problem (check all that apply)

☐ Acupuncturist
☐ Chiropractor
☐ Occupational Therapist
☐ Family practitioner
☐ Denstist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Internist
☐ Massage Therapy
☐ Neurologist/Neurosurgeon
☐ Obstetrician/gynecologist
☐ Other:_______________________________________
☐ Podiatrist
☐ Psychologist
☐ Physiatrist
☐ Rheumatologist

If you have seen any of the above practitioners in the last 3 months, what was it for? ____________________________
____

OTHER CLINICAL TESTS

Within the past year, have you had any of the following tests? (Check all that apply)

☐ Angiogram ☐Echocardiogram ☐Spinal tap
☐ MRI ☐ EEG (electroencephalogram)
☐ Stool tests ☐ Arthroscopy ☐ Biopsy
☐ EKG (electrocardiogram)
☐ Stress test (eg, bike or treadmill)
☐ EMG (electromyogram)
☐ Blood tests ☐ Bronchoscopy ☐ Urine tests
☐ Bone scan ☐ Myelogram ☐ X-rays
☐ CT scan ☐ Pulmonary function test
☐ NCV (nerve conduction velocity)
☐ Other: ____________________________________

Medications Do you take any prescription medications?
☐ Yes ☐ No

If yes, please list and include dosage, frequency, route (oral, topical, etc), and the reason for taking (please bring a complete list to your initial appointment)

Name	**Dosage**	**Frequency**	**Route**	**Reason Taking**

Have you taken any nonprescription medications in the last week? (check all that apply)

☐ Advil/Aleve
☐ Antacids
☐ Ibuprofen/Naproxen
☐ Laxatives
☐ Antihistamines
☐ Aspirin
☐ Decongestants
☐ Herbal supplements
☐ Tylenol
☐ Vitamins/Minerals
☐ Other: ___________
____

Allergies: List any medications you are allergic to:
____

Are you sensitive to latex or adhesives? ☐ Yes ☐ No

List any other allergies we should know about____

FUNCTIONAL STATUS QUESTIONNAIRE

Date of Injury/Onset: _______________

Cause of Injury/Onset: ____
Have you been seen in the past for this (or similar) injury? Yes _____ No _____

The following information lets us know how you are doing **TODAY**.

Please describe the nature of your pain, symptoms, or problems:
____
____

Please describe your current symptoms:
How often do you experience your symptoms within a day?
Constantly (76-100%) Frequently (51-75%) Occasionally (26-50 %) Intermittently (0-25%)

How are your symptoms changing?
Getting better Not changing Getting worse

How much has pain interfered with your normal work activities?
Not at all A little bit Moderately Quite a bit Extremely

How much has pain interfered with your normal daily living activities?
Not at all A little bit Moderately Quite a bit Extremely

Circle the word (s) that best describe your pain:

Constant	Intermittent	Cyclical	Sharp	Stabbing
Dull	Aching	Burning	Heaviness	Throbbing
Pulsating	Stinging	Discomfort	Tingling	Unpredictable

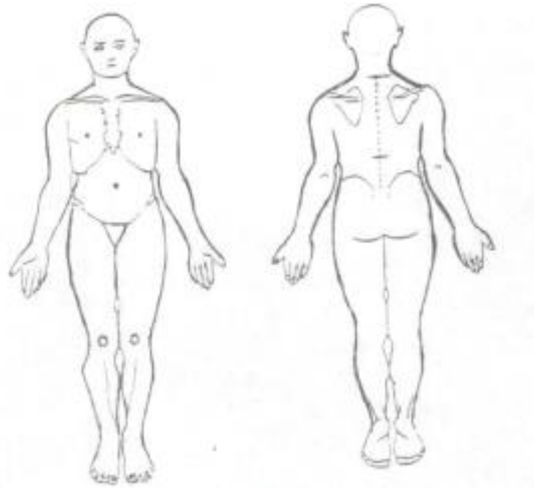
Symptoms are worse with (Circle all that apply):

Sitting	Rising from Sitting	Standing	Bending	Walking
Running	Squatting	Going Up Stairs	Going Down Stairs	Lying on Back
Lying on Side	Lying on Stomach	Reading	Driving	Lifting
Pushing	Pulling	Overhead Activity	When Still	When Moving
AM	PM	Other:		

Symptoms are better with (Circle all that apply):

Sitting	Rising from Sitting	Standing	Bending	Walking
Running	Squatting	Going Up Stairs	Going Down Stairs	Lying on Back
Lying on Side	Lying on Stomach	Reading	Driving	Lifting
Pushing	Pulling	Overhead Activity	When Still	When Moving
AM	PM	Other:		

Pain diagram
Use "X" marks on the figures below where you feel pain **TODAY**. Use **"/"** marks to show where you feel numbness, tingling, or pins and needles **TODAY**.



Visual Analog Scale: Please place a mark on the line below where you would rate the pain you feel **TODAY**.

No Pain |--| Worst Pain Imaginable

Please circle the number below which best represents your overall average level of function:

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

---

What are your personal goals for therapy at this time?

____

____

____

Please identify up to three important activities that you are unable to do and/or are having difficulty with as a result of your symptoms/ problem.

1.)____

2.)____

3.)____

I voluntarily give my permission to Movement Systems Physical Therapy to provide therapy services and treatment to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Movement Systems Physical Therapy, or until I withdraw my consent in writing.

______________________________________ ____________________

Signature of Patient or Guardian Date