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PATIENT REGISTRATION

Patient

First Name _____ MI ____ Last Name _____ DOB____/____/_____

Address_____City_____State_____Zip _____

Primary Phone ( )_____ Secondary Phone ( ) _____

Gender ☐ Male ☐ Female ☐ Rather Not Say ☐ Custom _____

Pronoun ☐ He ☐ She ☐ They ☐ Rather Not Say ☐ Custom _____

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

Insurance_____ Insurance_____ ☐ SELF PAY

ID No. _____ ID No. _____

Group No. _____ Group No. _____

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

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)

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AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Movement Systems Physical Therapy, P.S. (MSPT) as your Physical Therapist Service Provider. We are committed to providing high quality care and customer service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to the beginning of your treatment.

1. As a courtesy, we will verify your benefits to assist you in your financial planning, however you are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductible, co-payments, co- insurance amounts or any other patient responsibility indicated by your insurance carrier or amounts which are not otherwise covered by supplemental insurance.

2. You are responsible for knowing the terms of your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at MSPT, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at MSPT are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at MSPT; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

3. Please bring your **insurance card** and **photo ID** to your first appointment. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. When the insurance card or other necessary information is furnished, we will file a claim with your insurance; and you will be refunded any amount paid by your carrier.

4. We verify your insurance benefits and submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to MSPT, for application onto your bill

for services, all of your rights and claims for the physical therapy benefits to which you, or your dependents are entitled, under any federal or state healthcare plan, insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you.

5. You authorize MSPT and associated staff to release patient information acquired in the course of your examination and/or treatment including any and all medical records and other documents related to your treatment that is deemed necessary to process this claim to the necessary insurance companies, third party payers, or health care entities as they require to participate in your care. **It is important to notify us as soon as possible of any changes related to your insurance coverage.** Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. MSPT does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

6. You will be emailed or mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem.

7. Payment of any account balance is due within thirty (30) days of receipt of your billing statement. The balance of any account not paid within sixty (60) days will begin to accrue interest at the rate of .75% per month or the maximum allowed by applicable law (9% per annum). We accept payment by **check, cash, debit cards or all major credit cards.**

8. **Self-pay.** All cash based services and co-pays are required to be paid in full at time of service.

9. **No show or late cancellation.** A $100 no show or late cancellation fee will be applied to all patients that cancel their appointment with less than 24 business hours' notice, or later than 3:00 PM on a Friday for any appointment prior to a Monday appointment.

10. **Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $40.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

11. **Managed Care (HMO, PPO, etc.).** If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

12. **Medicare.** MSPT is a participating provider with the Medicare program and accepts the Medicare allowable. You understand that you will be responsible for your annual deductible, co-payment, co-insurance, and any non-covered services specified by Medicare as disclosed by an Advanced Beneficiary Notice (ABN). We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

13. **Workers' Compensation Cases/L&I.** Charges for services incurred as a result of a verified work-related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier or L&I. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information at the time of your first visit. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

14. **Third Party Liability Injuries.** As a courtesy, we will bill your third-party liability carrier/PIP carrier for services rendered. Because MSPT does not protect charges incurred relating to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments. MSPT cannot act as administrator to resolve financial arrangements. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the third-party/PIP carrier. We will also collect information about your personal medical insurance in case the third-party/PIP carrier denies your claim. Regardless of whether we submit your claim to third-party/PIP carrier, as the patient, you are ultimately responsible for payment.

15. **Non-payment on Account.** MSPT will work in collaboration with you to ensure timely payment of your outstanding balance. Should collection proceedings become necessary to collect an overdue or delinquent account, you understand that MSPT has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including late fees and interest due as a result of such delinquency. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history.

ACKNOWLEDGEMENT

I have read the financial policies contained above and my signature below serves as acknowledgment of understanding my financial responsibility.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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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.

Your appointment time is very important to us. In the event you need to cancel an appointment, we require at least **24 business hours notice (Monday and Weekend appointments MUST be canceled no later than 3pm of the prior Friday.)**. **If we do not get at least 24 business hours notice of your cancellation, or you do not arrive for your scheduled appointment (no show) you will be accessed a $100 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:

_____

_____

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EVALUATION INTAKE FORM

Please fill in **ALL** blanks. Write N/A, for not applicable.
Name (Last, First, MI):_____DOB:_____Sex:_____Date: _____
Gender ☐ Male ☐ Female ☐ Rather Not Say ☐ Custom _____
Pronoun ☐ He ☐ She ☐ They ☐ Rather Not Say ☐ Custom _____

Who referred you to MSPT? ☐ Doctor _____ ☐ Self ☐ Friend ☐ Other_____Dominant hand: ☐ Right ☐ Left

LIVING ENVIRONMENT:
Type: ☐ House ☐ Condo ☐ Apt. ☐ Other_____ ☐ Stairs ☐ Railings ☐☐ mps ☐ Elevator ☐ Other_____
☐ Alone ☐ Spouse ☐ Children (ages) _____ ☐ Roommate(s) ☐ Pet ☐☐ Other _____
Assistive Devices: ☐ Wheelchair ☐ Walker ☐ Cane/Crutch ☐ Other Assistive Device _____

EMPLOYMENT:
Occupation: _____ ☐ Full-Time ☐ Part-Time | ☐ Retired ☐ Unemployed ☐ Student
From: ☐ Home ☐ Office If not working, list last date worked:_____

SOCIAL/HEALTH HABITS:
Coffee/caffeinated beverages: ☐ Yes ☐ No; Cups/day ☐ 0-1 ☐ 2 ☐ 3 ☐ 4+
Alcohol: ☐ Yes ☐ No; Days/week ☐ 0-1 ☐ 2 ☐ 3 ☐ 4+; Drinks/day: ☐ 0-1 ☐ 2 ☐ 3 ☐ 4+;
Smoking: ☐ Tobacco ☐ Marijuana ☐ None | ☐ I Quit; Year(s) quit:_____; Total Years: ☐☐
History of substance dependency / abuse: ☐ Yes ☐ No
Other drug use: _____

EXERCISE/ACTIVITY: ☐ Yes ☐ No
Type(s): Currently:_____Previously:_____
Days/week: ☐ 0- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+; Hours/day: ☐ 0- ½ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
History of sport (type, years played, injuries): _____

GENERAL PHYSICAL/EMOTIONAL HEALTH:
Rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Recent life changes: ☐ Moving ☐ Employment ☐ Marriage/Divorce ☐ Childbirth ☐ Death in family ☐ Other:_____
☐ Yes ☐ No; Do you often worry about causing permanent damage to your body?
☐ Yes ☐ No; Have you felt down, depressed, or hopeless recently?
☐ Yes ☐ No; Have you been bothered by having little interest or pleasure in doing things recently?
☐ Yes ☐ No; Do you feel unsafe or has anyone tried to hit/injure you in any way?
☐ Yes ☐ No; Are you currently seeing a mental healthcare professional? Name:_____How long/often: _____
☐ Yes ☐ No; Are you interested in getting in contact with a mental health professional?

OTHER CLINICAL PROVIDERS: Check all that apply, including current, previous, and unrelated conditions

☐ Acupuncturist	☐ Internist	☐ Naturopathic Doctor	☐ Orthopedist	☐ Rheumatologist
☐ Chiropractor	☐ Massage Therapist	☐ Obstetrician/Gynecologist	☐ Osteopath	☐ Other_____
☐ Dentist	☐ Neurologist	☐ Occupational Therapist	☐ Podiatrist	_____

OTHER CLINICAL TESTING: Check all that apply, including current, previous, and unrelated conditions

☐ Xray	☐ Blood Test	☐ Angiogram	☐ Pulmonary Func. Test
☐ MRI	☐ Urine Test	☐ EKG/Echocardiogram	☐ Other_____
☐ CT	☐ NCV (Nerve Con. Vel.)	☐ Stress Test	_____
☐ Bone Scan	☐ Arthroscopy/gram	☐ Biopsy	_____

MISC.
Eyewear: ☐ Glasses ☐ Contacts ☐ None; Prescription, if known:_____
Earwear (hearing aides or other assistive devices): ☐ Yes ☐ No; Describe: _____
Foot Orthotics (OTC, prescribed, etc.): ☐ Yes ☐ No; Describe: _____
Oral Orthotics (splints, night guards, etc.): ☐ Yes ☐ No; Describe: _____

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MEDICAL HISTORY

Please check both **current** and **past** conditions. If applicable, please **list / describe** in space provided.

☐ Allergies:	☐ Dizzy Spells:	☐ MRSA / Repeated Infections:
☐ Anemia:	☐ Emphysema/Bronchitis/Lung Problems:	☐ Multiple Sclerosis:
☐ Anxiety:	☐ Fibromyalgia:	☐ Muscular Disease:
☐ Arthritis:	☐ Fractures:	☐ Osteoporosis / Osteopenia:
☐ Asthma:	☐ Gastrointestinal Problems:	☐ Parkinson's Disease:
☐ Autoimmune Disorder:	☐ Headaches/Concussions:	☐ Rheumatoid Arthritis:
☐ Cancer:	☐ Hearing Impairment:	☐ Seizures:
☐ Cardiac Conditions:	☐ Hepatitis:	☐ Smoking:
☐ Cardiac Pacemaker:	☐ High Cholesterol:	☐ Speech Problems:
☐ Chemical Dependency:	☐ High/Low Blood Pressure:	☐ Stroke:
☐ Circulatory / Vascular Problems:	☐ HIV/AIDS:	☐ Thyroid Disease:
☐ Currently Pregnant:	☐ Incontinence/ Bowel Problems:	☐ Tuberculosis:
☐ Depression:	☐ Kidney Problems:	☐ Vision Problems:
☐ Diabetes / Blood Sugar Problems:	☐ Metal Implants:	☐ Other:

FOR MEN: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

FOR WOMEN: Have you been diagnosed with or do you have:
☐ Pelvic inflammatory disease ☐ Endometriosis
☐ Painful periods ☐ Complicated pregnancy/delivery
☐ Other OB/GYN conditions _____

Within the **last year** have you had **any** of the following:

☐ Fever ☐ Constipation ☐ Chest pain / palpitations
☐ Nausea / Vomiting ☐ Urinary difficulty ☐ Loss of balance / falls
☐ Diarrhea ☐ Weight loss / gain ☐ Pain at night

SURGICAL HISTORY: Please list **all** surgeries, including dental and visual: Procedure Name (Date Performed):

_____ (/ /) _____ (/ /) _____ (/ /)
_____ (/ /) _____ (/ /) _____ (/ /)
_____ (/ /) _____ (/ /) _____ (/ /)

MEDICATIONS: Please include **all** current prescriptions. Fill in **all** information.

Name	Dosage	Frequency	Route	Reason Taking

Please list **all** non-prescription medications: (OTC medication, supplements, vitamins, etc.)

_____

_____

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FUNCTIONAL STATUS QUESTIONNAIRE

Please, answer the following based how you are doing **today.**
Date of Injury / Onset:_____Cause of Injury / Onset: _____
In the past, have you been treated for this or a similar injury? ☐ Yes ☐ No; If yes, when/where:_____

How often are you experiencing symptoms within one day?
☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

How are your symptoms changing?
☐ Improving ☐ Not changing ☐ Worsening

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

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

How would you describe your symptoms? Check all that apply:

☐ Dull	☐ Grinding	☐ Burning	☐ Throbbing
☐ Pulsating	☐ Clicking	☐ Sharp	☐ Unpredictable
☐ Aching	☐ Locking	☐ Heaviness	☐ Other:_____
☐ Stiffness	☐ Cramping	☐ Tingling	_____
☐ Weakness	☐ Stinging	☐ Stabbing	_____

What makes your pain worse? Check all that apply:

☐ Sitting	☐ Squatting	☐ Reading	☐ When still
☐ Rising from sitting	☐ Going up Stairs	☐ Driving	☐ When moving
☐ Standing	☐ Going down Stairs	☐ Lifting	☐ AM
☐ Bending	☐ Lying on back	☐ Pushing	☐ PM
☐ Walking	☐ Lying on side (R / L)	☐ Pulling	☐ Other: _____
☐ Running	☐ Lying on stomach	☐ Overhead activity	_____

What makes your pain better? Check all that apply:

☐ Sitting	☐ Squatting	☐ Reading	☐ When still
☐ Rising from sitting	☐ Going up Stairs	☐ Driving	☐ When moving
☐ Standing	☐ Going down Stairs	☐ Lifting	☐ AM
☐ Bending	☐ Lying on back	☐ Pushing	☐ PM
☐ Walking	☐ Lying on side (R / L)	☐ Pulling	☐ Other: _____
☐ Running	☐ Lying on stomach	☐ Overhead activity	_____

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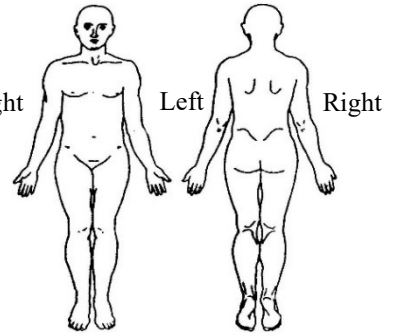
Please mark on the diagram with an **X** where you feel your symptoms. On the scale, mark the intensity of your symptoms.



No Pain — Worst Possible Pain

Please list your goals for physical therapy (example: Return to hiking without foot pain.)

_____

_____

_____

I voluntarily give my permission to Movement Systems Physical Therapy to provide therapy service 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