POWERED BY MOTION
PHYSICAL THERAPY

Patient Information

Patient Last Name: ____________________ First Name: ____________________ Middle I: _____

Birth Date: ___________ Age: ______ Height: _________ Weight: ________

Social Security #: _______-______-________

Address: ____ City: ________________ State: _____

Zip Code: __________ Different mailing address? _____________________________________

Contact Phone Number: (______) _______________ Alternate Number: (_____) ___________

Appointment Reminder (choose ONE):

Text Message Reminder: (______)__________________________

Phone Call Reminder: (______)_____________________________

Email Reminder: email address: _____________________________

Employer: ________________________________ Job Title: _________________________

Referring Physician: ___________________________ Phone: (_____) ________________

Primary Care Physician: ________________________ Phone: (_____) ________________

Insurance Company Name: ____

If you are **NOT** the Insurance Policy holder, please list Name and information below:

Name: ________________________________ Birth date: ____________________

Address: ______________________________ City: ______________ State: _____

How did you hear about us? ____

Is this a Car accident or an injury that happened at Work? **YES / NO** **CAR / WORK**

If this is an Accident/Work Injury, please Fill out Information below:

Insurance Company Name: ___________________________ Claim Number: ________________

Date of Accident: ___________ Adjusters Name: __________________ phone: (____)________

Employer if work related: ___________________________________ Phone: (____)___________

Do you have an attorney? Name: _____________________________Phone: (____)___________

Patient Medical History

Patient Name: ______________________________

Are you currently being treated for anything else? _____________________________________

Current medications: ____

____

Check all below that apply to you:

Heart Problems	Diabetes	Osteoporosis	Allergies
Pacemaker	Circulation disorder	Hernia	Dizziness
High blood pressure	Seizure	Nausea	Pregnancy
Fibromyalgia	Breathing problems	Joint replacement	weight loss

History of cancer: ____

History of Surgery: ____

Today's Treatment:

When did this problem start? ____

What caused the problem? ____

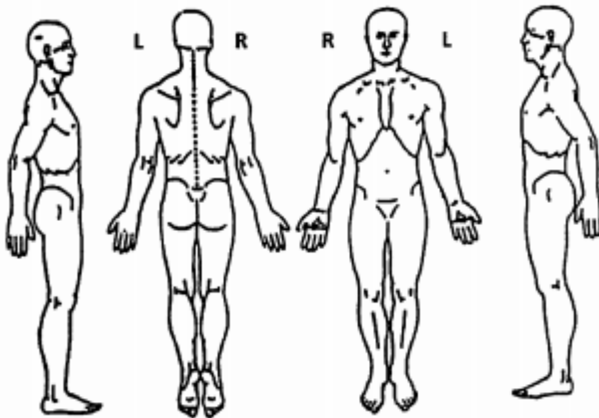
What makes it worse? ____

What makes it better? ____

Pain level at WORST: 0 1 2 3 4 5 6 7 8 9 10

Pain level CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Please draw your pain below to the best of your ability:



Patient Signature: ____ Date: _____________

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Authorization for Medical Record Disclosure

I, (name) ______________________________ give Powered By Motion PT permission to release and receive medical information to and from my Physicians, Insurance companies, and those listed here____

____. This information will be used on behalf of the patient to improve care and for communication of patient status. Third parties requesting my information must obtain my permission and will accept all responsibility and charges associated. This authorization will be in effect for as long as this documentation and records are kept and as legally required. I understand that any changes to this authorization must be submitted in writing to Powered By Motion PT. Our privacy practices are kept in the facility and are available to patients upon request.

Patient Signature: ______________________________ Date: _______________

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Patient Agreements

Appointment Reminders:

I give Powered By Motion PT permission to contact me for appointment reminders as indicated on the selected option on the Patient Information Form. All associated fees with reminders are the patient's responsibility. Pt may opt-out of reminders at any time submitted formally in writing.

⇒ Pt Initials: ___________

No-Show and Cancelation Policy:

I agree that I will give Powered By Motion PT cancelation notice **24 hours** prior to scheduled appointment time. Less than 24 hour notice will result in **$26.00 fee** charged to the patient for holding the appointment.

⇒ Pt Initials: ___________

Non-covered Services:

I understand that insurance companies may not cover certain services and supplies. I agree that it is my responsibility to verify with my carrier Physical Therapy benefits and covered services. I agree to financial responsibility for charges/services not covered by my insurance provider.

⇒ Pt Initials: ___________

Unpaid Balance Fee:

I agree to making monthly payments towards unpaid balances. If I do not make payments in over 90 day, I understand Powered By Motion PT will add finance charges and send my account to collections. I will contact Powered By Motion Billing services to set up payment method.

⇒ Pt Initials: ___________

Cash Pay Patient:

I agree to pay cash at time of service and that my insurance provider will not be billed.

⇒ Pt Initials: ___________

I have read the above and agree to initialed statements:

Patient Signature:____ Date: ________________