



Today's Date*: _____

PATIENT INFORMATION*

Name*: _____ Preferred Name: _____ Date of Birth*: ____/____/____

Cell Number*: _____ Home Number*: _____

Preferred phone for appt text reminders*: Cell listed above Other: _____

Email Address*: _____

Address*: _____ Apt/Unit # _____ City*: _____ State*: _____ Zip Code*: _____

Emergency Contact

Name*: _____ Phone Number*: _____

Relationship to Patient*: _____

Primary Care Physician

PCP Name*: _____ Phone Number*: _____

Referring Physician Information (if different from your PCP)

Referring Physician Name*: _____ Phone Number*: _____

How did you hear about Movement State?* _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

In an effort to comply with HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to list any person other than your doctor with whom we may discuss your private health information or financial matters. If you would like us to share private health information or financial matters, you may list these individuals below.

Name: _____ Relationship to patient: _____

Phone: _____

Name: _____ Relationship to patient: _____

Phone: _____

Cancellation & No-Show Policy*

I understand attendance is expected and vital to achieving physical therapy goals and outcomes. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment. **I acknowledge a cancellation of less than 24 hours or not showing up for an appointment will likely result in a late cancellation / no show charge of \$35.**

Signature*: _____

Date*: _____



Today's Date*: _____

Consent for Treatment*

I recognize that physical therapy and exercise programs may be difficult, strenuous and could be dangerous for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise do exist. These changes include, but are not limited to, abnormal blood pressure, fainting, disorders in heartbeat, heart attack, and in rare instances, death. I acknowledge and agree that I assume the risks associated with all activities and/or exercises in which I participate and will disclose any prior medical history that could increase my risk of experiencing an adverse response.

In signing this waiver and release, I acknowledge and represent that I have read and understand the foregoing and hereby sign it voluntarily as my own free act and deed.

I (**patient name, printed**)* _____ hereby authorize Movement State through its appropriate personnel to provide physical therapy services, injury prevention services, wellness screens and treatments to me or the above-named patient. The techniques used are considered medically necessary and proper for the assessment, diagnosing, and treatment of my/his/her physical condition. The treatment plan will be reviewed with me prior to implementation.

Signature of Patient/Legally Authorized Representative*

Consent for Treatment of a Minor (if applicable)

In my presence, or in case of my absence, I consent to having Movement State conduct examinations and perform procedures as are medically required and administer treatment as deemed necessary or advisable to the minor child noted below. I understand I may request a consultation with the treating therapist at any time.

Patient's Name/Minor's Name: _____

Patient/Legally Authorized Representative Name (Printed): _____

Signature of Patient/Legally Authorized Representative: _____

Communication Notifications Policy*

I hereby give consent to receive notifications from Movement State Physical Therapy which notifications may include my personal health information and appointment reminders by the following methods of communication: text message, phone call, and/or email. I understand the risks involved with such notifications from Movement State Physical Therapy. I agree to assume all responsibility for informing Movement State in writing of any changes to any of the methods of communication.

I indicate text messages, phone calls, and email are secure with password protection used where applicable. I further agree that Movement State shall not be held liable for any unauthorized disclosures of my personal health information to a third party through any of the methods of communication.

I **AGREE / DISAGREE** to be contacted by Movement State through phone call, text message, and/or email.
(circle one)

Signature*: _____



Today's Date*: _____

Photo Release Form

I hereby authorize Movement State and its agents to use, reproduce, and publish photographs, testimonials, statements, and/or video content that may contain my image, likeness, and/or voice. I agree and understand I shall neither be compensated for the content nor receive attribution for the content.

I also attest that I am authorized to grant to the right to use this content. I understand that this content may be used in publications, press releases, marketing materials, advertisements (both digital and print), websites (including social media sites), or other uses. This authorization is continuous, and only I may withdraw this authorization through specific, written rescission.

I hereby release from any liability of any kind related to the use, reproduction, or publication of the content. **No signature implies no permission given.**

Signature: _____

Insurance & Financial Policy Statement*

As a courtesy to you, Movement State will attempt to verify coverage with your insurance company. Movement State does not guarantee the accuracy of the information provided by your insurance company, nor do we guarantee your coverage.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health medical plan, to issue payment check(s) directly to Movement State for medical services rendered to myself and/or my dependents. I have requested medical services from Movement State on behalf of myself and /or my dependents(s) and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that the "Patient Financial Responsibility per visit" is based on benefits obtained at the time of service and is an estimate only and not a guarantee of payment. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are ultimately my responsibility.

I understand I am responsible for the entire balance of my bill. I understand and agree that treatments not covered or paid for by my insurance company may be my responsibility. I understand and agree that if I fail to make payments, in an effort to collect Movement State will seek third-party collection services and I will be responsible for all additional fees and costs of collecting money owed including court costs, and third-party collection fees. If any payment from any source is made directly to you for any services rendered by Movement State, I recognize an obligation to promptly remit those payments to Movement State.

Signature*: _____



PATIENT MEDICAL HISTORY FORM*

Patient Name: _____

Date of Birth: ____/____/____

What OUTCOME are you seeking here at Movement State Physical Therapy? _____

List any daily activities you are having difficulty performing; list any hobbies you would like to return to:

What is your chief complaint? _____ When did it start? _____

What is the cause of injury/condition? _____

Type of Surgery (if applicable): _____ Surgery Date: _____

Rate your pain: (0=no pain, 10=unbearable pain): Pain right now: _____ at its least: _____ at its worst: _____

Describe your pain (e.g. constant, intermittent, aching, dull, etc.) _____

What makes your pain better? _____

What makes your pain worse? _____

Please list all medications/supplements you are taking _____

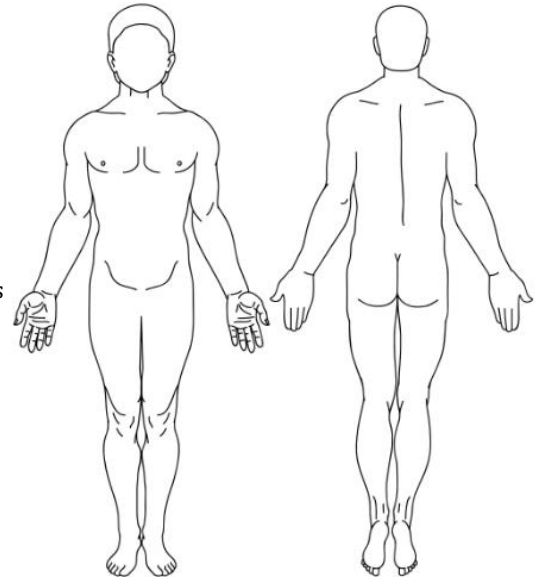
Have you had any of the following diagnostic exams?

- XRAY CT SCAN MRI Other Results: _____

Are any of the following part of your medical history? (Mark all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bypass/Pacemaker | <input type="checkbox"/> Stroke: Right/Left | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Headaches/Migraine | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Diabetes: Diet/Insulin | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Generalized Weakness | <input type="checkbox"/> Open Sores/Wounds | <input type="checkbox"/> History of Falls |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Brain Trauma | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Use: Tobacco/Alcohol/Recreational Drugs: _____ | | |
| <input type="checkbox"/> Fracture: Spine/Arm/Wrist/Hip/Leg/Ankle/Other: _____ | | |

Please indicate where you have pain or other symptoms:



To the best of my knowledge and belief, the information I have given is complete and true.

Signature of Patient/Legally Authorized Representative*

Date*