Total Motion
PHYSICAL THERAPY

56 N. College Ave, #1
College Place, WA 99324
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totalmotionpt@outlook.com

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Date of Birth: _____ ☐ Male ☐ Female SSN: _____

Appointment Reminders: ☐ Call Cell Phone ☐ Call Home Phone ☐ Text Message

Employer: _____ ☐ Student Work Phone: _____

Referring Physician: _____ Physician's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

If Married: **Spouse's Name:** _____ Employer: _____

Cell Phone: _____ Work Phone: _____

PLEASE COMPLETE IF PATIENT IS A MINOR:

Mother/Guardian's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ DOB: _____

Employer: _____ Address: _____

Father/Guardian's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ DOB: _____

Employer: _____ Address: _____

***INSURANCE INFORMATION*: Please present the front office with insurance cards**

Primary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID#: _____ Group#: _____ Date of Birth: _____

Secondary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID#: _____ Group#: _____ Date of Birth: _____

Is treatment a result of a: On the job injury Auto Accidental

Date of Injury: _____ Claim#: _____

Emergency Contact (not living with you): Name: _____ Phone: _____

I authorize Total Motion Physical Therapy, to use and disclose health and medical information for the purposes of treatment, payment, and health care operations. Under all circumstances, I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Total Motion Physical Therapy, for services rendered. I have received this practice's notice of Privacy Practices written in plain language.

Signature: _____ Date: _____

Patient History

Name _____ Age_____ Date_____

1. Describe the current problem that brought you here?_____

2. When did your problem first begin?___months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____

6. Describe previous treatment/exercises_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes
___ Walking greater than _____minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst ___

11. What are your treatment goals/concerns?_____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Other /describe_____

Y/N Malaise (Unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling

Pg 2 History Name_____

Health History: Date of Last Physical Exam _____ Tests performed_____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

Cancer
Heart problems
High Blood Pressure
Ankle swelling
Anemia
Low back pain
Sacroiliac/Tailbone pain
Alcoholism/Drug problem
Childhood bladder problems
Depression
Anorexia/bulimia
Smoking history
Vision/eye problems
Hearing loss/problems
Stroke
Epilepsy/seizures
Multiple sclerosis
Head Injury
Osteoporosis
Chronic Fatigue Syndrome
Fibromyalgia
Arthritic conditions
Stress fracture
Rheumatoid Arthritis
Joint Replacement
Bone Fracture
Sports Injuries
TMJ/ neck pain
Emphysema/chronic bronchitis
Asthma
Allergies-list below
Latex sensitivity
Hypothyroid/ Hyperthyroid
Headaches
Diabetes
Kidney disease
Irritable Bowel Syndrome
Hepatitis HIV/AIDS
Sexually transmitted disease
Physical or Sexual abuse
Raynaud's (cold hands and feet)
Pelvic pain
Other/Describe_____

Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe_____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #___
Y/N Episiotomy #___
Y/N C-Section #____
Y/N Difficult childbirth #_____
Y/N Prolapse or organ falling out
Y/N Other /describe_____
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? ___
Y/N Painful vaginal penetration
Y/N Pelvic pain

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Other /describe_____
Y/N Erectile dysfunction
Y/N Painful ejaculation

Medications - pills, injection, patch Start date Reason for taking

Over the counter -vitamins etc Start date Reason for taking

Name_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe _____

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements ____ times per day, _____times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please complete only one)

___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

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PHYSICAL THERAPY

HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment

We may use medical information about you to provide you with medical treatment or other service related to your care. We may disclose medical information about you to doctors, nurses, technicians, or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Billing

If you submit an invoice to your health plan for reimbursement, your health plan will be informed of dates of services and the procedure codes on that invoice. We will not use or disclose any medial information to your health plan without specific written authorization from you.

If you have any questions about any of our policies or your rights, please feel free to ask us.

Your signature below indicates your understanding and acceptance of the above privacy practices.

_____ _____

Patient Name Printed Patient/Guardian Signature

_____

Date

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Cancellation and No Show Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one, 45-minute treatments, missed appointments are a significant inconvenience to your physical therapist, the clinic and other patients.

This policy is in place out of respect for our therapist AND our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot, and leave a 45-minute hole in your therapist's schedule.

1. ***Please provide our office with 24-hour notice to change or cancel an appointment.*** Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 service charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. We reserve your 45-minute appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to offer that time to a wait-listed patient.

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioner(s) to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. If you fail to show for three scheduled treatment sessions, not only will you be subject to the $50.00 cancellation fee per visit, but you may be discharged from physical therapy.

NOTE: *You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.*

Thank you for providing our office and our patients with courtesy.

I have read, understand, and agree to abide by the policy above:

Print Name: _____

_____ _____

Signature of Patient (or Responsible Party) Date

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Patient Financial Responsibility Policy

Thank you for choosing our office. Total Motion Physical Therapy appreciates the confidence you have shown in choosing us to provide for your physical therapy needs and we are committed to providing you with the best possible care. The medical services you seek imply a financial responsibility on your part. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have any questions regarding your financial responsibility.

Statement of Financial Responsibility: Our office accepts patients that have physical therapy insurance as well as patients that don't have physical therapy insurance. Regardless of your insurance status, you are financially responsible for treatment provided to you and/or your legal dependent by this office. **As a courtesy, we will bill your insurance. However, the insurance estimates we give you are based on limited information obtained from your insurance company.** You are therefore directly responsible to us for payment of treatment. Payments can be made by cash, check, debit, and credit card (Visa, Mastercard, Discover, and American Express). There will be a $35.00 charge for all returned checks. By signing this form, you authorize your insurance plan to make payments for covered services directly to our office. **You are responsible to pay at the time of service any deductibles, non-covered services and your portion not covered.** However, the insurance estimates we give you are based on limited information obtained from your insurance company. If there is a balance on your account, a statement of charges will be sent to your mailing address and you may receive phone calls from this office and/or third-party asset recovery agency. Any unpaid balances older than 30 days will be considered delinquent and subject to a 1% monthly interest fee. By signing this form, you authorize this office and its agents to communicate with your insurance company, in accordance with their privacy policy, regarding policy coverage. You further authorize this office to release information to make payment for services rendered.

Please understand that outstanding charges over 90 days may be sent to an asset recovery agency. By signing this form, you authorize this office and its agents to release your information in order to collect past due balances. By signing this from, you understand and accept that all collection fees, attorneys' fees and costs are your responsibility.

I have read the front and back of this form and agree to the terms and understand my responsibilities.

_____ _____

Signature of Patient or Legal Guardian/Guarantor Date

_____

Print Name of Patient

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It is extremely important that you are aware of your insurance coverage for physical therapy. Please review the following information. Our office staff will try to answer any questions you might have.

Private Insurance: Coverage of physical therapy is included in most insurance policies; however, you are expected to check your specific policy for appropriate coverage since you are responsible for payment of your account. It is your responsibility to notify us in any changes in your insurance coverage, failing to do so could result in non-coverage. We will gladly bill your primary insurance company, but **nothing is a guarantee of payment by your insurance company and the remainder will be your responsibility.**

Co-payments: Your insurance plan determines your co-pay and they require that we collect your designated co-payment at the time of service. Please be prepared to pay the co-payment at each visit. If you are unable to pay your co-payment at the time of your visit, you will be charged a $5.00 fee.

Non-Participating Insurance Plans: As a courtesy to our patients, TMPT will bill your non-participating insurance plan. Any outstanding balances are the responsibility of the patient.

Referrals: If your insurance requires a referral from your Primary Care Physician, **it is the patient's responsibility** to obtain your referral prior to your appointment and to have it with you at the time of your appointment. If you don't have the referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**

Medicare: Our office accepts Medicare Assignment, which means our clinic will accept the Medicare approved charge as the full charge for covered services. Medicare will then pay 80% of the approved charge. The beneficiary of their Medicare Supplement is responsible only for the 20% that the Medicare does not pay plus any unmet deductible. Our clinic bills Medicare directly. **Please let us know if you are receiving Home Health Care services. Medicare will not cover out-patient physical therapy if you are receiving Home Health Care.**

Automobile Accident/Worker's Comp Cases: Patients shall be financially responsible for medical services related to automobile/worker's comp. It is the responsibility of the patient to notify TMPT of the date of injury, claim #, insurance company address, phone number, and contact person. If your motor vehicle claim exhausts, or your worker's comp claim denies, it will be the patient's responsibility to submit to TMPT any other insurance plan that you may have, or the charges will be considered the patient's responsibility. If your insurance plan is a non-participating plan with TMPT and your motor vehicle exhaust or worker's comp denies, you will be responsible for any unpaid charges.

Self-Pay: You will be considered self-pay if you have no insurance coverage or if you choose to not go through your private insurance. This means we will **not be billing any insurance and you will be fully responsible for the payment.** The **payment for each visit is due at the time of the visit**. We are able to offer you this lower rate than insurance, because we will not be billing your insurance in any way. If you choose to go through participating/non-participating insurance at any time we could start from that visit and on, but we will not back bill for any visits.