Total Motion
PHYSICAL THERAPY

56 N College Ave, # 1
College Place, WA 99324
Phone: (509) 876-8900
Fax: (509) 593-4006
Totalmotionpt@outlook.com

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone:_____

City: _____ State: ____ Zip: _____ Email: _____

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's Name: _____

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

Secondary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer's Name: _____

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

Is treatment a result of an: ☐ 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: _____

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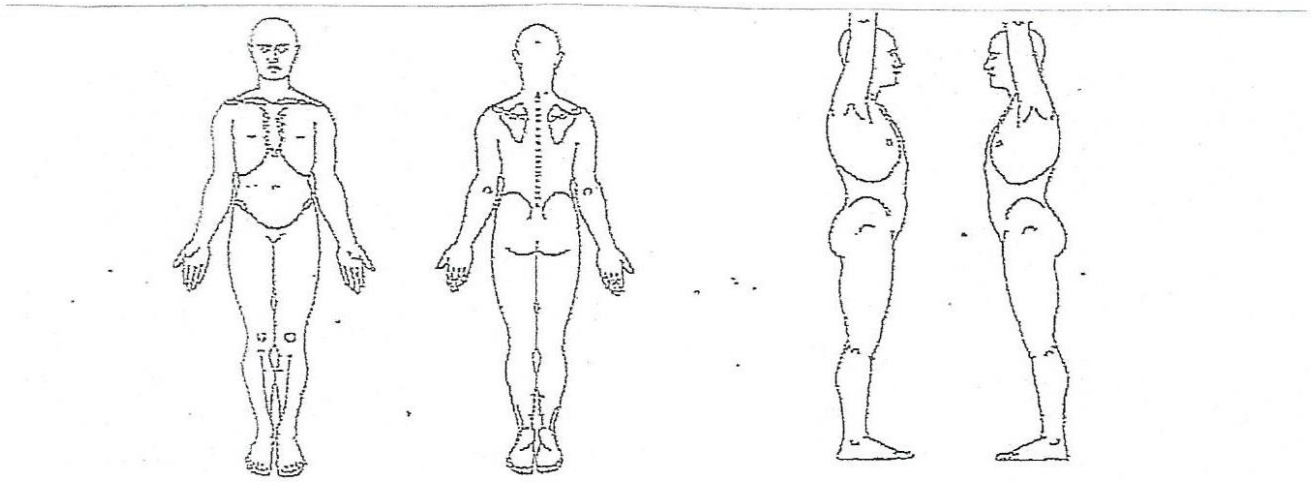
Office Use Only	
BP: _____	**HR:** _____
Height: _____	**Temp:** _____
Weight _____	

Please indicate the areas where you are experiencing pain/symptoms. Use the symbols in the table below to describe your pain/ symptoms.

XXX Pain	OOO Pins and Needles	//// Other



Current Complaints:

_____

_____

_____

If you are having any pain, rate the severity on a scale of 0-10, where 0 is no pain and 10 is the most severe pain (circle a number on each line):

At This Time: 0 1 2 3 4 5 6 7 8 9 10

At Worst: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

Other Complaints:

_____

_____

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MEDICAL HISTORY SCREEN Date: _____

List all Medications:

_____

_____

_____

Have you or any immediate family member been told you/they have:

	Self	Family
Cancer	□Yes □No	□Yes □No
High Blood Pressure	□Yes □No	□Yes □No
Heart Disease	□Yes □No	□Yes □No
Angina/Chest Pain	□Yes □No	□Yes □No
Osteoporosis	□Yes □No	□Yes □No
Arthritis	□Yes □No	□Yes □No

Do YOU have a history of:

Joint replacement/Implants	□Yes □No
Allergies/Asthma	□Yes □No
Headaches	□Yes □No
Breathing Problems	□Yes □No
Kidney Disease	□Yes □No
Ulcers	□Yes □No
Seizures	□Yes □No

Have you had or do you experience:

Recent change in your health	□Yes □No
Nausea/Vomiting	□Yes □No
Fever/Chills	□Yes □No
Unexplained weight loss	□Yes □No
Dizziness or Falls	□Yes □No
Bowel/Bladder changes	□Yes □No

Are you Currently:

Pregnant	□Yes □No
Depressed	□Yes □No
Under Stress	□Yes □No

Are your Symptoms:

□ Getting Worse
□ Remaining the Same
□ Improving

Do you have a Pacemaker? □Yes □No

Date of last Physical Examination:

_____

How well do you sleep at night?

□ Fine
□ Moderate Difficulty
□ Only with Medication

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HIPPA 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 medical 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.

Please check the box next to the individuals we are allowed to discuss your medical information with, including but not limited to, your appointment information, billing and other account details.

☐ Spouse/Partner Name: _____

☐ Other Family Members Name(s): _____

Your signature below indicates you understand and accept 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 therapists 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 canceled 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:

_____ _____

Patient Name Printed Patient/Guardian Signature

_____

Date

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Patient Financial Responsibility Policy

Thank you for choosing our office. Total Motion Physical Therapy appreciated 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, insurance estimates we give you are based on limited information obtained by 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. 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 you portion not covered.** 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 form, you understand and accept that all collection fees, attorney's 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.

_____ _____

Patient Name Printed Patient/Guardian Signature

_____

Date

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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.