MOVEMENT SOLUTIONS
Physical Therapy

PATIENT CONTACT INFORMATION

Patient Name_____ Date_____
Address_____
City_____ State_____ Zip _____
DOB_____ Age _____ Gender_____ Marital Status_____
Cell Phone _____ Home Phone _____
Email_____ Medicare#: _____
Employer_____ Occupation_____

Emergency Contact Information
Name_____Relationship_____
Cell Phone_____ Home Phone_____

PATIENT QUESTIONNAIRE

Referring Physician_____

Date of Onset/Injury/Accident _____

History of current condition

_____
_____
_____

What is this condition most limiting you from doing that you need, want, or love to do?

_____
_____

Please list all previous surgeries

_____
_____
_____

Please list all current medications

_____
_____

Please list any allergies

_____

MOVEMENT SOLUTIONS
Physical Therapy

Check if you currently have or previously had any of the following:

Arthritis	_____	High Blood Pressure	_____
Asthma	_____	Gout	_____
Cancer	_____	Seizures	_____
Circulation Problems	_____	Stroke	_____
Diabetes	_____	Ulcers	_____
Heart Problems	_____	Other Illnesses	_____

Please Specify if necessary: _____

_____

Circle if you have had any of the following performed for current condition:

X-RAY MRI CT SCAN

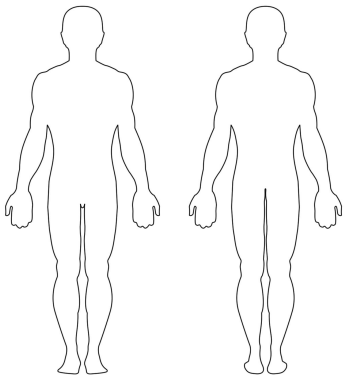
Are you currently being treated by:

Another Therapist: Yes or No OR within last 12 months: Yes or No

Chiropractor/Osteopath: Yes or No OR within last 12 months: Yes or No

Home Health Agency: Yes or No OR within last 12 months: Yes or No

In picture below circle areas of pain/discomfort you are experiencing



Front **Back**

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____

MOVEMENT SOLUTIONS
Physical Therapy

OFFICE POLICIES & PROCEDURES

CANCELATION POLICY

As a courtesy to other patients and our Therapists **we require a 24-hour (or greater) notice for cancellations**. This allows others on waiting lists to be seen. Only emergencies or illnesses are excusable. **A $60 fee will be billed upon violation of this policy.** **Initial _____**

CONSENT TO TREATMENT

- Movement Solutions Physical Therapy is a hands-on Physical Therapy clinic. Forms of deep tissue massage, graston, myofascial release, bone and soft tissue manipulation, and trigger point dry needling. The associated risks with such techniques may include: bruising, bleeding, muscle soreness for 2-3 days following treatment, light headiness, nausea, and potentially a pneumothorax if dry needling over the lung field.
- If treatment is performed over the lung field, if at any time after the treatment you experience shortness of breath, difficulty taking in a deep breath, coughing, or chest pain after the procedure, report to emergency room and inform them you have had dry needling over your lung field. They most likely will get an x-ray and give you the required treatment.
- Alternative treatments: stretching of the muscle where the trigger point is located, deep tissue massage, using thera cane, lacrosse ball, or other tools.
- The number of treatments needed and recovery time can vary widely due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Movement Solutions Physical Therapy and I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery. **Initial _____**

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Movement Solutions Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Movement Solutions Physical Therapy to release all medical information and records necessary to secure payment for services rendered.

Initial _____

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at the time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Movement Solutions Physical Therapy, you must promptly remit such payment directly to Movement Solutions Physical Therapy.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Initial _____

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS.

X _____ Date: _____
Signature of Patient/Guardian

PATIENT PRIVACY POLICY & PROCEDURE STATEMENT

Dear Patient:

Movement Solutions Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality of care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contract our Privacy Officer at 704-604-0568.

Movement Solutions Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

X_____ Date _____
Signature of Patient/Guardian

Movement Solutions Physical Therapy
Photograph, Video, & Testimonial Release Form

I understand that Movement Solutions Physical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Any photographs or videos taken during initial evaluation, progress evaluation and discharge summary may be used for postural comparison purposes and as educational tools. I understand that my photograph or video, or my child's, may be taken during participation in any activity with Movement Solutions Physical Therapy. Please select one of the following options:

☐ I hereby grant permission to Movement Solutions Physical Therapy to use my photograph (or my child's if child is the patient) or likeness in any publicity or promotional publications (e.g. website, social medical, newspaper ads, bulletin boards, newsletters, programs, brochures, public broadcasting releases, etc.) and to allow videoing of me or my child for broadcast I do not grant permission for photographs of me (or my child if child is the patient) to be used for publicity or promotional purposes.

☐ I do not grant permission for photographs of me (or my child if child is the patient) to be used for publicity or promotional purposes.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read and fully understand the above statements.

X_____ Date_____

Signature of Patient/Guardian