MotionPro Physical Therapy and Wellness

PATIENT INTAKE FORM

Patient Name:_____ **Date:**_____

Date of Birth:_____ **Circle one: Male Female**

Current Street Address:_____

City:_____ **State:**_____ **Zip:**_____ _____

Is this your Primary Billing Address: Yes No

Home Phone:_____ **Mobile:**_____ _____

Email Address:_____

Referring Physician Name:_____**Phone:**_____

Primary Care Physician Name:_____ **Phone:**_____

Community/development where you reside:_____

How did you hear about us? (circle one)

Doctor **Word of Mouth** **Advertisement** **Internet Search** **Other**

If you circled Word of Mouth or Other please provide the name of the person who referred you or specify how you found us: _____

5725 Corporate Way, Suite 209
West Palm Beach, FL 33407
Phone: 561-834 3330
Fax: 561-834 3445

MotionPro Physical Therapy and Wellness

CLIENT CONSENT TO TREATMENT (Please Initial)

_____ I have stated all known medical conditions on the Patient Intake Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions. I realize it is solely my responsibility to keep MotionPro Physical Therapy & Wellness and the attending therapist updated on any changes in my physical health and I understand that MotioPro Physical Therapy& Wellness and the practitioner shall not be liable should I fail to do so.

_____ I understand that although skilled care will be provided throughout the treatment process, certain risks do apply. These risks include, but are not limited to, injury to muscles, tendons, bones; elevated heart rate, blood pressure and respiration rate. By signing this release, I hereby waive and release MotionPro Physical Therapy &Wellness and its therapists, from liability of injury excepting acts of negligence.

_____ I understand MotionPro Physical Therapy &Wellness is obligated to abide by the Health Insurance Portability and Accountability Act (HIPPA) and understand the notice and how it relates to my personal information. MotionPro Physical Therapy &Wellness is required to provide you with a copy of our Notice of Privacy Practices which states how we may disclose/use your health information. I acknowledge that I have received a copy of MotionPro Physical Therapy & Wellness Notice of Privacy Practices. If I wish my medical information be shared with another party, I must provide written permission with exact names included.

_____ I understand that I am financially responsible for all services rendered at MotionPro Physical Therapy & Wellness. All questions regarding fees should be asked prior to service. If my insurance changes, I am responsible for notifying MotionPro Physical Therapy& Wellness prior to my appointment, otherwise I will be responsible for the full payment of the visit. I understand that if my account balance is not paid in full, it may be forwarded to a collection agency. If any delinquent account balance is referred to a collection agency, I understand that I will be financially responsible for all costs relating to the collection of my debt.

_____ I understand that MotionPro Physical Therapy &Wellness reserves my appointment time and That a 24-hour notice of cancellation is required. We reserve the right to charge a $30 cancellation appointment fee the same day of the visit. The practice is aware that emergencies can arise but repeated cancellations can result in a charge.

5725 Corporate Way, Suite 209
West Palm Beach, FL 33407
Phone: 561-834 3330
Fax: 561-834 3445

MotionPro Physical Therapy and Wellness

MEDICARE REGULATION DISCLOSURE

Medicare regulations require us to make you aware of our billing procedures and your financial responsibility. MotionPro Physical Therapy & Wellness accepts Medicare Assignment for skilled physical and occupational therapy. Medicare will pay 80% of the reimbursable service charges. We will bill your co-insurance for the remaining 20%. If you do not have a secondary insurance or if your secondary insurance does not pay, we will bill you directly for the balance. I have received the policy statement, and have read and agree to the policies therein.

Patient Signature_____ Date_____

RELEASE OF PERSONAL HEALTH INFORMATION TO THIRD PARTY BILLING CO.

I authorize Ledger Resolutions, LLC, Jet PT Billing can be reached via email at Kevin@jetptbilling.com Phone Number: 319 653-5494 , a third-party billing company, to use and disclose my Personal Health Information for the purpose of processing my medical claims.

Patient Signature _____ Date_____ _____

PATIENT EMERGENCY CONTACT CONSENT

I authorize MotionPro Physical Therapy& Wellness to communicate directly with th following individual in regards to my health care:

Emergency Contact Name _____ Relationship_____
Telephone_____

PATIENT TELEPHONE CONSENT

AT MotionPro Physical Therapy & Wellness, we are required to call the patient to confirm scheduled appointments. This acknowledges that you authorize MotionPro Physical Therapy and Wellness to: (please initial)

Yes_____ No _____ Leave a detailed message with the party answering your telephone

Yes_____ No _____ Leave a detailed message on your answering machine or voicemail

PATIENT NAME:_____ **DATE:**_____

5725 Corporate Way, Suite 209
West Palm Beach, FL 33407
Phone: 561-834 3330
Fax: 561-834 3445

MotionPro Physical Therapy and Wellness

Patient Name:_____ Date:_____

Please Check Any Applicable Conditions Either Current or Personal History

____High/Low Blood Pressure ____Osteoporosis ____Spinal Stenosis ____Arthritis
____Chest Pain/Angina ____Cancer ____Diabetes ____Heart Disease ____Headaches
____Neuropathy ____Heart Attack ____Dizziness ____Herniated/Bulging Discs
____Pacemaker ____Memory Deficits ____Parkinson's Disease ____Kidney Disease
____Stroke/CVA ____Epilepsy ____TMJ ____Fever ____Allergies.

Briefly explain and give approximate date for all checked conditions. Also, include any surgeries and approximate dates. Indicate below any additional past medical history which has not been listed.

_____

_____

Have you had any fall in the past year (circle): NO YES How many: _____ Please explain:

_____

_____

Current Medications (please indicate prescription and non-prescription)

Medication	Dosage	Frequency	Route of Administration	Reason for Taking

5725 Corporate Way, Suite 209
West Palm Beach, FL 33407
Phone: 561-834 3330
Fax: 561-834 3445

MotionPro Physical Therapy and Wellness

Primary Insurance Information

Insurance Name:_____ **Subscriber Name:**_____

Member ID#_____ **Date of Birth:**_____

Relationship to

Subscriber:_____

Secondary Insurance Information

Insurance Name:_____ **Subscriber Name:**_____

Member ID#_____**Date of Birth:**_____

Relationship to Subscriber:_____

5725 Corporate Way, Suite 209
West Palm Beach, FL 33407
Phone: 561-834 3330
Fax: 561-834 3445