HEALING MOTION
PHYSICAL THERAPY

Patient Information

Patient Name: _____
First Last Middle Initial

Preferred Name: _____ Date of Birth: _____
(MM/DD/YYYY)

Mailing Address: _____
Street or PO Box City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-Mail: _____
□ *I agree to receive information from Healing Motion regarding news, events, and exclusive offers.*

Appointment Reminder Preference: □ Text □ Email □ Voice (Home) □ Voice (Cell) □ Voice (Work)

Date of Injury/Onset: _____ Have you had any Physical Therapy this year? □ Yes □ No

Who may we thank for referring you? _____

Where have you heard or seen us? (Check all that apply):
□ Facebook □ Google □ Instagram □ YouTube □ Twitter □ Radio
□ Billboard □ Family & Friends □ Doctor □ Other: _____

Insurance Information

Primary Insurance Plan: _____ Work/Auto: □ Yes □ No

ID/Policy#: _____ Group#: _____

Secondary Insurance Plan: _____

ID/Policy#: _____ Group#: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

Patient's Authorization to Release Medical Records

I authorize Healing Motion Physical Therapy, Inc. to request/send/release medical records that are in relation to my physical therapy care. I understand that there may be a $30.00 fee for a FULL records request.

_____ _____

Patient or Authorized Representative Signature Date

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Patient Acknowledgement & Consent

I understand and agree that Healing Motion Physical Therapy may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among other health care providers for my care and treatment;
- Determine my eligibility for health insurance and submit bills, claims, and other related information to my insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various administrative and business functions that support efforts to provide me with, and be reimbursed for, cost effective health care.

I understand that my health information may include information both created and received by Healing Motion Physical Therapy, and may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I also understand that I have the right to receive and review a written description of how Healing Motion Physical Therapy will handle health information about me. This written description is known as Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the staff of Healing Motion Physical Therapy, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of the most recent version of the Privacy Practices in effect is available for review from the office receptionist.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I also understand that Healing Motion Physical Therapy is not required by law to agree to such requests.

By signing below, I agree that I have received and understand the information above.

_____ _____

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Appointment Fees and Billing Procedures

Appointments

Attendance at all scheduled appointments is extremely important. Our appointments are on a 45-minute basis. If you are late for your appointment, your therapist may feel it necessary to do only a portion of your treatment or reschedule for another day. If a scheduling conflict occurs, please call us at 541-929-2255 (Philomath) or 541-250-4525 (Corvallis) as soon as possible. We may be able to use your time for another patient and reschedule you for a more convenient time.

Appointment Fee Policies

I understand that the responsibility for attending appointments that are scheduled is mine. If desired, a reminder card will be given when the appointment is scheduled. Additionally, an appointment reminder will be sent to you prior to each appointment. If a no show, late cancellation, or late arrival occurs, **you will be billed** at the following rate. **Please initial next to each fee.**

_____ NO SHOW: If you do not arrive to a scheduled appointment you will be billed $90.

_____ LATE CANCELLATION: We ask for at least 24-hours' notice for cancellations. If you call to cancel with less than 24-hours' notice, you will be billed $90.

_____ LATE ARRIVAL: If you arrive more than 15-minutes late to your scheduled appointment, you will be billed $30.

Co-Payments

Please be aware of your insurance benefits and be prepared to pay any co-payments you may have at each appointment.

Assignment of Insurance Benefits

By signing below, you assign and authorize payments to be made directly to Healing Motion Physical Therapy, Inc. the insurance benefits which would otherwise be payable to you for physical therapy expenses. A photocopy of this assignment and authorization is considered as valid and effective as the original.

Notice Regarding Insurance Benefits

You understand that you are responsible for charges incurred with Healing Motion Physical Therapy which are not covered through your insurance. As a service to you, we will complete and submit your insurance claim. All fees and expenses incurred by you in this clinic, not compensated by your insurance company are solely your responsibility. Regardless of any insurance claims, full payment is due in less than 60 days.

_____ _____

Patient or Authorized Representative Signature Date

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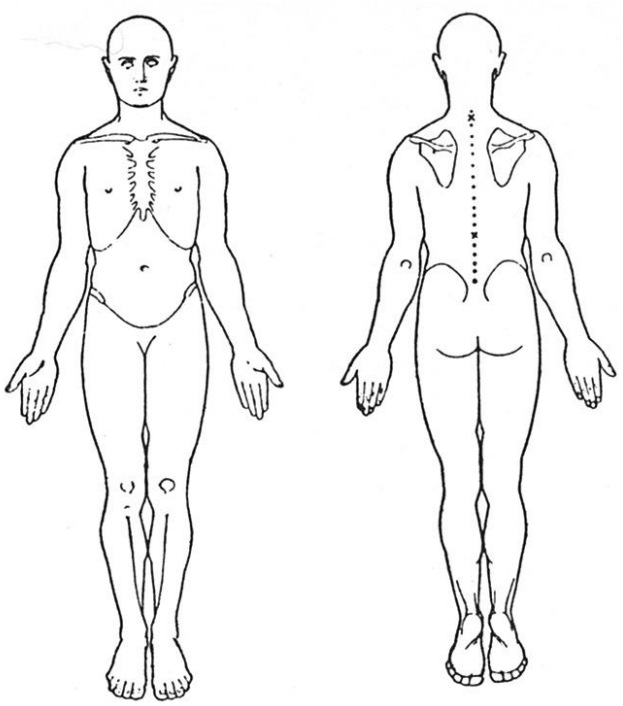
Healing Motion Intake & Medical History Form

Name: _____

Please shade in the location of your symptoms



Social History

Marital Status _____
Occupation _____
Do you smoke? □ Yes □ No
Did you used to smoke? □ Yes □ No
Do you chew tobacco? □ Yes □ No
Do you drink alcohol? □ Yes □ No
Frequency: _____
Do you exercise? □ Yes □ No
Frequency: _____

Primary Care Physician _____

Surgical History

Please list any recent and relevant surgeries (type and date)

_____
_____
_____
_____
_____

Medication List

Please attach your current medication/supplement list. Include medication/supplement name, dosage, frequency, and how it is administered (i.e. oral, injection, topical, etc.). If you did not bring your list, complete the following:

Name	Dosage	Frequency	Method of Administration

Medical History

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
□ Yes □ No
During the past month, have you often been bothered by little interest or pleasure in doing things?
□ Yes □ No

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Cardiovascular	Past	Current	Explain
Heart disease			
High blood pressure			
High cholesterol			
Palpitations			
Chest pain on exertion			
Shortness of breath			
Swelling of arms and/or legs			
Family history cardiovascular disease			
Anemia			
Blood transfusion			
Stroke/TIA			
Clotting disorder			
Seizures			
Blood clots			
Respiratory	**Past**	**Current**	**Explain**
Wheezing			
Prolonged cough			
Sputum			
Pneumonia			
Tuberculosis			
COPD			
Emphysema			
Asthma			
Pulmonary embolism			
Gastrointestinal	**Past**	**Current**	**Explain**
Heartburn			
Nausea			
Vomiting			
Constipation			
Diarrhea			
Change in color of stools			
Rectal bleeding			
Abdominal pain			
Liver problems			
Gallbladder problems			
Musculoskeletal & Arthritides	**Past**	**Current**	**Explain**
Osteopenia			
Osteoporosis			
Fracture			
Long-term steroid use			
Rheumatoid Arthritis			
Systemic Lupus Erythematosus			
Gout			
Osteomyelitis			
Psoriatic Arthritis			
Ankylosing Spondylitis			
Osteoarthritis			

Neurological	Past	Current	Explain
Numbness/tingling both hands/feet			
Unexplained difficulty walking			
Double vision			
Difficulty speaking			
Difficulty swallowing			
Drop attack			
Involuntary eye movement/dizziness			
Numbness			
Change in bowel/bladder function			
Change in sensation in bowel/bladder region			
Migraines			
Dizziness/vertigo			
Urological & Reproductive	**Past**	**Current**	**Explain**
Painful urination			
Blood in urine			
Incontinence			
Frequent urination			
Urinary urgency			
Difficulty initiating urination			
Severe menstrual cramps			
Postmenopausal bleeding			
Painful intercourse			
Urinary infection			
Irregular vaginal discharge			
STD			
HIV/AIDs			
Decreased force of urinary flow			
Impotence			
Urethral discharge			
Pregnancy			
Other Conditions	**Past**	**Current**	**Explain**
Diabetes			
Kidney disease			
Thyroid problems			
Night pain			
Unexplained weight loss			
Cancer			
Family history cancer			
Fever			
Chills			
Sweats			
Extreme fatigue			
Lightheadedness/Fainting			
Recent infection			
Drug/IV use			
Anxiety/panic attacks			
Allergies (tape, etc.)			
Other			