HEALING MOTION
PELVIC HEALTH

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: _____

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

Appointment Reminder Preference: □ Text □ Email Date of Injury/Onset: _____

Have you had any Physical Therapy this calendar year? □ Yes □ No
Please notify our front office if you are currently seeking therapy at another clinic.

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: _____

ID/Policy#: _____ Group#: _____

Secondary Insurance Plan: _____

ID/Policy#: _____ Group#: _____

Is this a Worker's Compensation or Auto Accident case? □ Yes □ No
If yes, please answer the following questions:

Insurance Name: _____ Adjuster's Name: _____

Adjuster's Phone #: _____ Adjuster's Email: _____

Claim #: _____ Date of Accident: _____ State of Accident: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Phone: _____

HEALING MOTION
PELVIC HEALTH

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 understand that artificial intelligence support tools may be used during our visits to record and process conversations during treatment, allowing the provider to focus on patient care. The recordings will be used solely for clinical purposes, not shared or sold.

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.

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.

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

_____ _____

Patient or Authorized Representative Signature Date

HEALING MOTION
PELVIC HEALTH

Appointment Policies and Billing Procedures

Appointments

Attendance at all scheduled appointments is extremely important. Our appointments are on a 45-minute basis. If a scheduling conflict occurs, please call us as soon as possible. We may be able to use your time for another patient and reschedule you for a more convenient time.

Appointment Policies

By signing below, you acknowledge that the responsibility for attending appointments that are scheduled is yours. 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. **The following guidelines will be used for no shows and late cancellations under 24 hours prior to any appointment:**

1st Occurrence: Grace is given. We are all human. Things happen.

2nd Occurrence: A reminder of our policy will be given.

3rd Occurrence: All upcoming appointments will be cancelled and given to a wait-listed patient.

The occurrence expires 90 days from when the occurrence happened. Three occurrences in any 90-day period will result in the cancellation of all remaining appointments.

Late Arrivals: If you are 10 minutes late or more, a **$30 fee will be applied and collected** before the appointment can begin **or the appointment may be cancelled and counted as an occurrence** for the 90-day period.

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. Balances owed will be collected prior to each session. Alternatively, you can sign the "Card on File Authorization Form," allowing us to charge your card automatically for any balance due on the 15th of each month. Full payment is due within 30 days of being posted to your account.

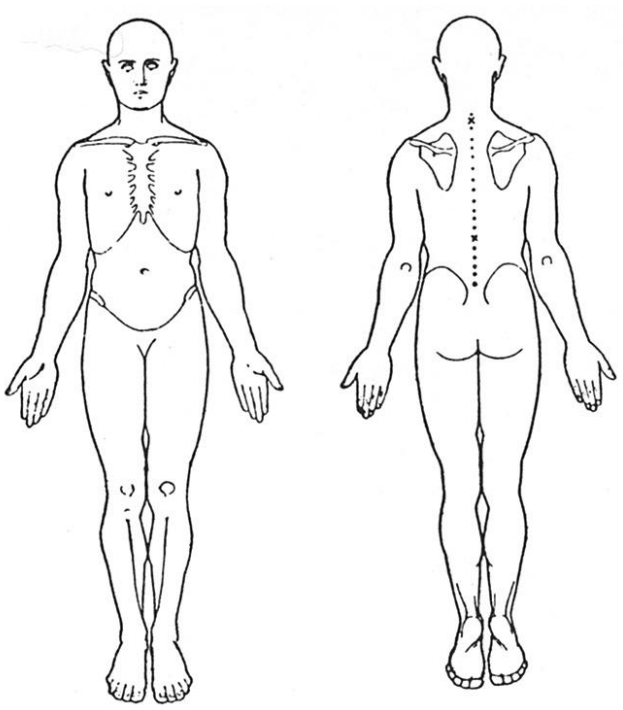
_____ _____

Patient or Authorized Representative Signature Date

HEALING MOTION
PELVIC HEALTH

Healing Motion Intake & Medical History Form

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: _____

What things do you enjoy doing?

_____

_____

_____

Primary Care Physician _____

Surgical History

Please list any recent and relevant surgeries.

_____

_____

_____

Please answer the following questions in relation to the symptoms bringing you to physical therapy today.

Describe the quality of your symptoms: _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you had any imaging? □ Yes □ No

What do you hope to accomplish with physical therapy?

_____

_____

Current Medication List - *Please include name, dosage, frequency, and administration method (i.e. oral)*

Name	Dosage	Frequency	Method of Administration

Medical History

During the past month, have you been bothered by feeling down, depressed, or hopeless? □ Yes □ No

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

HEALING MOTION
PELVIC HEALTH

Pelvic Health	Past	Current	Explain
Constipation			
Diarrhea			
Rectal bleeding			
Pain or straining to pass stool			
Stool incontinence			
Painful urination			
Blood in urine			
Urinary frequency or urgency			
Urinary incontinence			
Difficulty initiating urination			
Severe menstrual cramps			
Post-menopausal bleeding			
Painful intercourse			
Urinary infection			
Irregular vaginal or urethral discharge			
STD/STI			
HIV/AIDs			
Decreased force of urinary flow			
Impotence			
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			
Change in color of stools			
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 sensation in bowel/bladder region			
Migraines			
Dizziness/vertigo			
Parkinson's disease			
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			