Demographics

Name (preferred):____________________________________ Date:______________ DOB: _____________ Age: _______
Name (Legal, if different): _____________________________ Gender Identity: _________ Preferred Pronoun: ________
Emergency Contact: __________________________________ Phone: _______________ Relationship: _______________
Address: ____ City/State/Zip: _____________________________________

Insurance

Primary Insurance: _____________________ Member ID: ___________________________ Group: __________________
Secondary Insurance: ______________________________ Member ID: _______________
Is this a Motor Vehicle Accident: □ Yes □ No Is this an L&I Claim: □ Yes □ No Date of Injury: _____________
PIP/L&I Claim#: _____________________ PIP Claim Adjuster Name: ______________________ Phone: ______________
I give the following person(s) access to: □ Billing □ Medical Charts □ Make Appointments
Name: _________________________ Relationship: ________ **Signature**: _________________________ **Date**: ________

Financial & Office Policies

Please be on time for your appointment. If you are late, it will shorten your time with your therapist and can interfere with the quality of care you may receive. We understand that the unanticipated events happen occasionally. It is our desire to be effective and fair to all patients and out of consideration for therapists, we ask for a 24-hour advance notice for all cancellations. Continued late cancellations or missed appointments may result in being released from care.

** We accept the following forms of payment: cash, personal checks, debit cards, most major credit cards. Payment is expected at the time of your visit. We will bill your primary insurance company as a courtesy to you. As the patient, you are always responsible for the payment of your care received in our office. An insurance contract is between the patient and their insurance company.

**Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patients, the latter may file a grievance directly with the insurance company. Your signature below authorizes this office to release daily chart notes when necessary and allow for collection of benefits for the processing of claims.

**The office manager may approve account balances. Active monthly payments are required if the account is not paid in full. An account that has not received a payment for 60 days may be sent to a third-party collection agency. Any additional collection fees will be the responsibility of the patient NFS check or rejected credit card payments will be charged a service of $35 per occurrence.

**In some cases, we may have a contract with your insurance governing how we handle your account. This contract may prevent us from offering you out AT TIME OF SERVICE discount. Please ask the front desk if you have any questions regarding this.

**Feel free to ask any financial questions you may have regarding your insurance or our billing procedures that you may have. Our intent is to provide you with the highest level of service and care.

**Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company and you will be responsible for your account regardless of insurance.

By signing below, I acknowledge that I understand the policies as contained herein.

Patient Signature: ____________________________________ **Printed**: _________________________ **Date**: ___________
Guardian (if patient is a minor):___________________________________ Relationship:___________________________

Informed Consent for Physical Therapy

You are an important partner in your healthcare decisions and play an active role in the outcome of your medical care. Thus, it is important that you are informed about benefits, risks, evaluations, and decisions about your care while being seen at this facility. If you have questions, symptoms or problems related to your care it is your responsibility to notify your physical therapist and consult with your primary care provider as necessary.

Your personal health information, which includes your entire medical history and information about services provided to you, is protected by law. This health record serves as a basis for planning your treatment for third-party payers and a tool to improve your care based on outcomes. Although this record is property of the healthcare provider, this information also belongs to you and you have rights regarding the privacy of your records. A copy is available to you upon request. In order to provide the best care possible, we may need to discuss your case with other healthcare professionals and healthcare facilities. By signing below, I authorize TrueMotion Physical Therapy, LLC and it's a therapist to release my medical records to my physician and my other healthcare professionals. PLEASE LIST PERTINENT HEALTH PROFESSIONALS AND THEIR CONTACT INFORMATION: ________________________________

Please initial the following statements:

____ I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic record 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 have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the treatments as outlined above by a Physical Therapist at TrueMotion Physical Therapy. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment at this facility.

____ I agree that I have been informed of my protected health information, privacy practices that keep my medical records secure and how to obtain a personal copy of this form and privacy policy.

____ I agree to be treated by TrueMotion Physical Therapy, LLC knowing there may be potential risks along with benefits and I am willing to be an active participant in my own care.

By signing below, I acknowledge that I understand the policies contained herein.

Patient Signature: ___________________________________ **Printed**: ________________________ **Date**: ___________

Guardian (if patient is a minor):__________________________________ Relationship:___________________________

Health History

Reason for visit? _______________________________

____

Date of injury/when symptoms began: ______________

Surgery Performed? ☐ Yes ☐ No

Type: ____

Date of Surgery: _______________________________

Was the onset/time of this episode:

☐ Gradual ☐ Sudden

Any previous episodes: ☐ Yes ☐ No

How did your injury occur?

☐Unknown ☐ While lifting

☐ Car accident ☐ Fall (Date: ________)

☐ Trauma ☐ At work

☐ Overuse

☐ During recreation/sports

☐ Other_________________________________

Since onset, are your symptoms getting:

☐ Better ☐ Worse ☐ Staying the same

TRUEMOTION
PHYSICAL THERAPY

Health History Continued

Please shade in region(s) of pain or abnormal sensation:

Nature of pain/symptoms:

□ Sharp □ Aching □ Dull
□ Throbbing □ Periodic □ Constant
□ Occasional
□ Other: ________________________________

Rate your pain on a scale 0-10. Place 3 circles:
(Best, Current, Worst)

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Previous Functional Level:

□ Independent in all activities
□ Independent in all self-care activities
□ Difficulty performing self-care activities
□ Need assistance with self-care activities
□ Difficulty performing household chores
□ Need assistance with activities in community, outside of home

Current functional level: What specific activities are you *unable* to do because of your symptoms?
____
____

What positions, activities, and time of day *aggravates* your symptoms? ______________________________
____

What positions, activities, and time of day *relieve* your symptoms? __________________________________
____

Have you had previous treatment for this condition? (Please describe): ______________________________
____

Have you had any imaging done for your condition?

□ X-Ray □ MRI □ CT Scan
□ Other: ______________________________

Occupation: __________________________________

□ Full-time □ Part-time □ Retired
□ Student □ Other

List any allergies to food or medications: ____________
____

How would you rate your general health?

□Excellent □ Good □ Average
□Fair □ Poor

Do you have a prior or current history of smoking?

□Yes □ No
How many packs a day? _________________

What are your goals coming to Physical Therapy?
____
____

Please complete any of the following conditions you may have had:

□ Anxiety/Depression
□ Heart Disease □ Pacemaker
□ Back Injury □ Lung Disease
□ Migraines/Headaches □ Epilepsy
□ Stroke □ Seizures
□ Fibromyalgia □ Visual Problems
□ Diabetes □ Fatigue
□ Cancer □ Autoimmune Disease
□ Hepatitis □ Pregnant
□ Osteoporosis □ Vertigo/dizziness
□ Hepatitis □ Head Injury
□ Chronic Pain □ Asthma
□ High Blood Pressure □ Sleep Disorder
□ Other: ______________________________

The statements made on this form are accurate to the best of my knowledge and I agree to be examined at TrueMotion Physical Therapy, LLC for treat of my symptoms.

Signed:_______________________________ **Print Name**:___________________________ **Date**:_____________