Name: _____ DOB:____/_____/_____ Age: _____

Address: _____ City:_____ State: ____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Gender: ○Male ○Female

Email: _____ Social Security #: ____/____/_____

Marital Status: (circle one) ○M ○S ○W ○D ○Other: _____ Height:_____ Weight:_____lbs

Emergency Contact: _____ Phone: (____) _____-_____ Relationship: _____

How did you hear about us?_____ Referring Physician: _____

Date of Injury:_____ How many times do you exercise each week? ○1-2 ○3-4 ○5+

Appt Reminders Preference (Choose 1): ○Email ○Text If Text, which Phone Carrier? _____

Surgeries	Month/Year of Surgery
_____	____/____
_____	____/____
_____	____/____

How did injury occur?

Describe Current Symptoms (what brings you to Physical Therapy):

Please check any activities you had difficulty performing **prior** to your injury:

☐Bathing ☐Dressing ☐Walking ☐Self Grooming
☐Sitting ☐Carrying Objects ☐Self Care ☐Negotiating Obstacles
☐Sleeping ☐Mobility ☐Climbing Stairs
☐Standing ☐Lifting Objects ☐Grasping Objects

Current functional limitations (What daily activities & exercise are currently limited due to your injury?):

☐Bathing ☐Dressing ☐Walking ☐Self Grooming
☐Sitting ☐Carrying Objects ☐Self Care ☐Negotiating Obstacles
☐Sleeping ☐Mobility ☐Climbing Stairs
☐Standing ☐Lifting Objects ☐Grasping Objects

On a scale of 1-10 with 10 being the most pain and 1 being the least:
Level of pain at its worst: Current pain level: Level of pain level at its best:
Describe Pain (check relevant choices): ☐Burning ☐Sharp ☐Dull/Achy ☐Throbbing ☐Shooting
☐Numbness/Tingling ☐Constant ☐Intermittent ☐Worse in A.M. ☐Worse in PM ☐Worse while sleeping

What makes your pain worse: _____

What makes your pain feel better:_____

What practitioners (other than your M.D.) have you tried for this condition?

☐ PT ☐ Chiro ☐ Acupunture ☐ Other: _____ Approximately how many visits? _____

Occupation: _____ Employer's Name: _____

Are you currently working, off work, or retired? _____

Present/Past Condition:	(circle if applicable)				
Asthma	Yes	No	Heart Attack	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No
Cancer	Yes	No	Hernia	Yes	No
Chemical Dependency	Yes	No	High Blood Pressure	Yes	No
Circulatory Disease	Yes	No	Kidney Disease	Yes	No
Depression	Yes	No	Implants	Yes	No
Diabetes	Yes	No	Multiple Sclerosis	Yes	No
Dizziness	Yes	No	Anxiety Disorder	Yes	No
Eating Disorder	Yes	No	Numbness	Yes	No
Emphysema/COPD/ARDS	Yes	No	Osteoporosis	Yes	No
Epilepsy	Yes	No	Pregnancy	Yes	No
Fainting/Fatigue	Yes	No	Planning a pregnancy	Yes	No
Neurological Disease	Yes	No	Stroke or TIA	Yes	No
Headaches	Yes	No	Thyroid Problem	Yes	No
Hepatitis/AIDS	Yes	No	Tuberculosis	Yes	No
Fever/chills/sweats	Yes	No	Weakness	Yes	No
Weight change	Yes	No	Night Pain	Yes	No
Nausea/vomiting	Yes	No	Allergies	Yes	No
Gastrointestinal Disease	Yes	No	Incontinence	Yes	No
Urinary frequency changes	Yes	No	Sleep Dysfunction	Yes	No
Visual impairment	Yes	No	Hearing impairment	Yes	No
Previous Accidents	Yes	No	Periph Vasc Disease	Yes	No
Angina	Yes	No	Back Pain	Yes	No

If yes was answered to any of the above, please explain:

Recent tests (x-rays, MRI, nerve conduction tests, bone scans): _____

List all current medications (prescription, over the counter, supplements):

Your Goals for Physical Therapy:

Your Physical Goals beyond Physical Therapy:

After physical therapy is complete, do you want help learning how to exercise effectively, safely and efficiently?
Yes No

Patient Signature: _____ Date: _____

Guarantor (if under 18): _____ Date: _____

IN MOTION O.C.
FINANCIAL POLICY

FINANCIAL POLICY STATEMENT

As a courtesy to you, **In Motion O.C.** has pre-verified your insurance benefits and will bill your insurance for you, if applicable. **The fees your insurance pays and the portion you may be responsible for is decided by your insurance company and not In Motion O.C. Your insurance policy is a contract between you and your insurance company. You are responsible for the entire bill for services rendered.** If we bill your insurance carrier and we do not receive full payment within 90 days, it is viewed as a refusal to pay: the balance will be immediately due in full from you. This usually results when the insurance carrier is holding the claim for review of pre-existing condition and other insurance information requested from the patient. In the event your insurance carrier performs a post treatment review and deems the services not medically necessary, you will be financially responsible for those denied charges. In the event that your insurance company requests a refund of payment made, upon *In Motion O.C.* presenting you with notice of the refund made, you will be immediately responsible for the entire amount of money refunded to your insurance company. In the event your employer establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining. In the event that payment is made directly to you for services billed by us, you agree to immediately contact In Motion O.C. to let us know that you have received the compensation and to immediately pay In Motion O.C. the amount that you have just received. If you claim Workers Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

_____
Initial

Credit Card Authorization

It is our policy to obtain credit card information. **We will charge your credit card automatically anytime there is a balance due** for any copay, co-insurance, deductible, returned check or cancellation/no show fee. If we are estimating your co-insurance each visit (because it's not a set amount), then sometimes there will be a balance due after treatment. If that happens, then you will know as you will receive your Explanation of Benefits before we do. If there is ever any overpayment, then we will issue you a refund for the difference. If you would like a receipt, just ask us for one. If at any time you would like to switch cards, just let us know.

Visa / MC / Amex / Discover (Circle One) Name on Card:_____

Card #:_____ Exp Date:_____ Zip Code:_____ 3 Digit Code:_____

Signature:_____ Date Signed:_____

MISSED APPOINTMENTS

As with almost all providers, we require 24 hours advance notification for any appointment that needs to be cancelled. When patients cancel late, or no shows, it is usually not possible to fill up that empty slot. Therefore, it is In Motion O.C.'s policy to charge a $30.00 fee.

_____
Initial

TERMS AND LATE FEES

In Motion O.C. provides net thirty (30) payment terms to the patient. This means that the invoice is due within thirty (30) days of being sent. If **In Motion O.C.** does not receive payment within thirty (30) days of the invoice being sent, patient will incur a late fee of 2% per month (24% APR) on the balance that is past due, including previously accrued late fees.

_____
Initial

CONSENT FOR TREATMENT & TO DISCUSS YOUR CASE

I, the undersigned, do hereby agree and give my consent for *In Motion O.C.* to furnish medical care and treatment to: _____, as considered necessary and proper in evaluating or treating his/her physical and mental condition. I hereby instruct and direct my Insurance company to issue check(s) made out and mailed directly to: ***In Motion O.C.***, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. **I also do hereby agree and give my consent for *In Motion O.C.* to discuss my health care information, my case and my account with the following people:**
Name(s):_____

_____
Initial

FOR PATIENTS WITHOUT A PRESCRIPTION

Per the 'Direct Access' laws, since you don't have a prescription, we are legally required to advise you of the following. "You are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist."

_____
Initial

ARBITRATION PROVISION

Except for any proceedings that may be initiated by In Motion O.C. in small claims court for payment under the terms of this Financial Policy, any dispute, claim or controversy arising out of or relating to this Financial Policy or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Orange County, California before one arbitrator. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. At the option of the first to commence an arbitration, the arbitration shall be administered by JAMS under its Streamlined Arbitration Rules and Procedures. Either party requesting arbitration under this Agreement must make a demand on the other party by registered or certified mail with a copy to JAMS. The arbitration will take place as noticed by JAMS regardless of whether one of the parties fails or refuses to participate. The parties' acknowledge that the patient has signed a separate Physician-Patient Arbitration Agreement which governs the rights of the Physician and Patient related to the provision of medical services.

BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE RELATING TO THIS AGREEMENT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____
Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of ***In Motion O.C.*** health care operations. The Notice of Privacy Practices also describes my rights and ***In Motion O.C.***'s duties with respect to my protected health information. ***In Motion O.C.*** reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent me via mail, fax, or e-mail, or by asking for a copy at my next visit at the clinic. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that ***In Motion O.C.*** is not required to agree to the restrictions requested.

_____
Initial

I have read, understand, and agree to all of the above. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____
Patient/Guardian/Responsible Party Date