Today's Date:____________________________

PATIENT INFORMATION

Last Name:___________________________ First Name:___________________________

Date of Birth:__________________________ Social Security#:_______________________

Address:______________________________ City:______________ State:____ Zip:______

Home Phone:________________________ Work Phone:______________________________

Email Address:______________________________________ Cell Phone:_______________

Marital Status Single Married Widowed Divorced Other:___________________

Referring Physician's Name____

Additional Physicians seen at this time:____

PATIENT EMPLOYER INFORMATION

Employment Status: Full Time Part Time Retired Self-Employed Unemployed

Employer:____ Occupation:______________

Employer Address:__________________________________ City:____________________

State:_______________ Zip:________________ Work Phone:________________________

INSURANCE INFORMATION

Primary Insurance: ____

Identification#:_________________________________

Group#:_______________________________________

Policyholder: Self Spouse Parent Other:_________________________________

If other than self, please specify policyholder information:

Name:____ Date of Birth:_________________

Policyholder's Address:____

City:____________________________ State:__________________ Zip:_______________

Social Security#:_______________________________ Employer:____________________

Employer's Address:____

Secondary Insurance: ____

Identification#:__________________________________

Group#:_______________________________________

If other than self, please specify policyholder information for secondary insurance:

Name:____ Date of Birth:_________________

Policyholder's Address:____

City:____________________________ State:__________________ Zip:_______________

Social Security#:_______________________________ Employer:____________________

Employer's Address:____

RELEASE OF INFORMATION AUTHORIZATION: *In case of emergency, please contact:*

Name:___________________________________ Relationship to Patient:______________

Day Phone#:__________________________ Evening Phone#:______________________

Are there any other persons we may release information to? If yes, whom? (please list all Names and relation to you; ex: spouse, parent, child, other relative, friend, etc):

____

AUTHORIZATION FOR PAYMENT

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payments to medical benefits to InMotion Physical Therapy & Wellness, LLC, its Successors and assigns, or any person it may designate for services provided. I further agree to pay all costs of collection including attorney fees, associated with collection of any amount due to services rendered and performed. I understand that I am financially responsible to InMotion Physical Therapy & Wellness LLC, its successors and assign any person it may designate due any balance not covered by insurance.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY/PARENT/GUARDIAN:

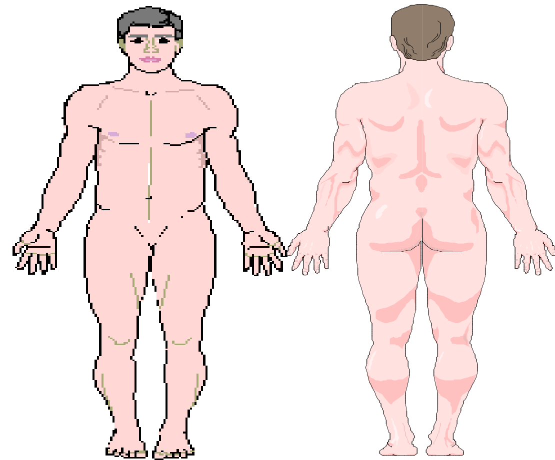
____ Date:_________________

Medical History

Patient:____Date:____________

Are you working: Full duty Light duty Retired N/a
Off due to this problem First lost day of work:__________
What is your main goal for therapy?____
Date of injury/onset:___________

1. Please indicate where your problem is located on the body chart below:
2. How were you injured?-______________
   ____
   ____
3. Please check if you have had any of the following:
   X-rays MRI CT Scan



5. Have you ever had these symptoms before? Yes No
6. What makes your pain better?____
   ____
7. What makes your pain worse?____
   ____
8. Have you had a related injury? Yes No
9. Do you have or have you had any of the following:

Diabetes	Yes	No	Hypoglycemia	Yes	No
Chest Pain	Yes	No	Osteoarthritis	Yes	No
High Blood Pressure	Yes	No	Osteoporosis	Yes	No
Heart Disease	Yes	No	Hernia	Yes	No
Heart Attack	Yes	No	Seizures	Yes	No
Heart palpitations	Yes	No	Metal Implants	Yes	No
Pacemaker	Yes	No	Dizziness/fainting	Yes	No
Headaches	Yes	No	Fracture	Yes	No
Kidney Problems	Yes	No	Surgeries	Yes	No
Cancer	Yes	No	Skin Abnormalities	Yes	No
Stroke	Yes	No	Nausea/vomiting	Yes	No
Bowel/Bladder Prob.	Yes	No	Ringing in ears	Yes	No
Urine Leakage	Yes	No	Varicose Veins	Yes	No
Asthma/Breathing Prob.	Yes	No	Smoking	Yes	No
Liver/Gall Bladder Prob.	Yes	No	Pregnancy	Yes	No
Hepatitis (type __)	Yes	No	Contacts	Yes	No
Allergies: list please	Yes	No			

Please list anything else you feel we should know about your problem or medical history:
____

What medications are you currently taking? Anti-inflammatory Pain Steroid
Blood thinner Blood pressure Other:________________________________

Consent for Treatment and Authorization to Release Information

I herby authorize this establishment, through its appropriate personnel to perform appropriate assessment and treatment. I further authorize this establishment to release to appropriate agencies, any information acquired in the course of my examination and treatment.

Patient's Signature: ____Date:______________

Outpatient Therapy Form 1
HIPPA Notice of Privacy Practices

Patient Name:________________________________

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be sued and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other patients at our office. In addition, we may use a sign in sheet at the registration desk where your will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donations; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at this time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indication in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

Outpatient Therapy Form 1 Page 2
HIPPA Notice of Privacy Practices Continued

You have the right to inspect and copy your protected health information. Under federal law, however, you may inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to prohibited health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively IE: electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

The signature below states that I have reviewed the above information.

Signature:____ Date:_________________

A) HIPPA Privacy Practices Notice Acknowledgement
B) Statement of financial responsibility

A) HIPPA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number (330) 336-8700.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:____

Signature:______________________________________ Date:______________________

B) Statement of financial responsibility

We appreciate the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for payment in full of your bill. You are responsible for payment of any deductible, co-payment and/or co-insurance, as determined in your contract with your insurance carrier. We expect payment at the time of service. You are responsible for any amounts not covered by your insurer. If your insurance denies any part of your claim, or if you or your physician elects to continue therapy past your approved period you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to our establishment for providing rehabilitative services to me or the above names patient. I certify that the information is to the best of my knowledge, true and accurate. I authorize my insurer to pay this establishment the full and entire amount of the bill incurred by me or the above name patient.

Patient Signature:____ Date:__________________

Guarantor Signature:_______________________________________ Date:__________________