How did you hear of us? MD Friend Newspaper Advertisement Other: _____

PATIENT INFORMATION (Please PRINT all information) *** Please list today's date** _____

Patient name First _____Middle _____ Last _____
If minor, Parent name also First _____Middle _____ Last_____

Patient Date of Birth _____ If minor, Parent Date of Birth also_____

Address _____

City _____ State _____ Zip _____

If P.O. Box, please list street address _____

Home phone _____ Cell phone _____

Employer _____ If minor, Parent employer _____

Work phone # _____ If minor, Parent work # _____

Physician _____ Location / Name of Clinic _____

Is this a worker's compensation claim? *(see note on bottom of page) YES NO **Injury date** _____

Is this a motor vehicle accident claim? *(see note on bottom of page) YES NO **Accident date** _____ **State**_____

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Electronic Statement

_____Please check here if you would prefer to receive your bill electronically to the email address below.

Security Question: Which city were you born in?_____

Email Request Form

Back in Motion Physical Therapy and Sports Medicine requests your Email address in order to provide you with important medical information on a timely basis.

We assure you that we will **NOT** share your Email address with any 3rd party.

_____
Primary Email address

_____
Patient's name (please Print)

_____
Patient's Signature **Date**

_____

- ICD 10 Code _____ Scan in _____ Letter _____ Email _____ Address _____ Insurance _____

FINANCIAL POLICY

Thank you for choosing Back in Motion Physical Therapy and Sports Medicine, Inc. as your physical therapy provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment.

- Patients should provide accurate and complete personal and insurance information prior to being seen by the therapist.
- Co-pays are due at each appointment.
- Deductibles, personal balances, both current and prior, are due at time of service.
- We accept cash, check and credit cards.

Regarding Health Insurance: We participate in numerous insurance plans. For most insurances, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be *personally* liable for the balance not covered by insurance. Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company. We will work with you to determine the extent of your insurance coverage and payment options; however, we recommend that you contact your health insurance provider to verify your coverage. In cases of financial need and other circumstances, billing adjustments may be an option.

Past Due Accounts: 1 ½% interest will be added to patient balances over 30 days. If your account becomes overdue, it may be referred to a collection agency and/or lawyer. Legal fees that we pay to secure past due balances will be added to your account. In case of suit, you agree the venue shall be in Dane County, Wisconsin. In the event your account is submitted to an outside source for collection, you give your permission to release the necessary information, personal or otherwise, to the outside source and you are aware that this information may become a matter of public record.

Returned Checks*:* A $35.00 fee will be charged for each check returned to us unpaid by your bank.

I have read the Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Back in Motion Physical Therapy and Sports Medicine, Inc. Furthermore, I agree to assign all health insurance benefits directly to Back in Motion Physical Therapy and Sports Medicine, Inc. *If the patient is a minor (under age 18), a parent or legal guardian must sign this agreement.*

_____ _____

PRINT Patient's Name Signature of Patient, Parent, or Legal Guardian Today's Date:_____

Would you like a copy of our HIPPA privacy notice? YES NO Received _____ Refused _____

BACK IN MOTION
Physical Therapy & Sports Medicine, Inc.

4722 Farwell Street, McFarland, WI 53558
Phone: 608.838.7232 Fax: 608.838.7405
www.feelbetterfaster.net

Cancellation and No Show Policy

Dear Patient,

In order to schedule patients with the care that they need, and for the consideration of other patients, Back in Motion Physical Therapy and Sports Medicine requires:

- ***A 24 hour cancellation notice if a patient is unable to keep a scheduled appointment time.***
- ***If a patient fails to show up for an appointment without notifying the office, a $20.00 fee will be charged to the patient for the missed appointment.***
- ***If you call in advance, there will be no charge.***

If a patient misses 2 appointments without calling, Back in Motion Physical Therapy and Sports Medicine will make every effort to contact the patient to reschedule the appointments. If no contact is made, all additional appointments will be removed to allow for accommodation of other patients.

If you have any questions regarding this policy, please discuss it with your therapist.

I have read the Cancellation/No Show Policy and I agree to the terms and conditions outlined within this policy:

Signed _____ Date _____

Name: _____ **Date:**_____

Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis
❑ high blood pressure	❑ asthma	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy
❑ blood clots	❑ other arthritic condition	❑ eye problem/infection
❑ stroke	❑ bladder/urinary tract infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ bone or joint infection	❑ sexually transmitted disease/HIV	❑ hepatitis
❑ chemical dependency (i.e., alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ diabetes	❑ tuberculosis
❑ heart problems	❑ stroke	❑ thyroid problems
❑ high blood pressure	❑ depression	❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____
Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

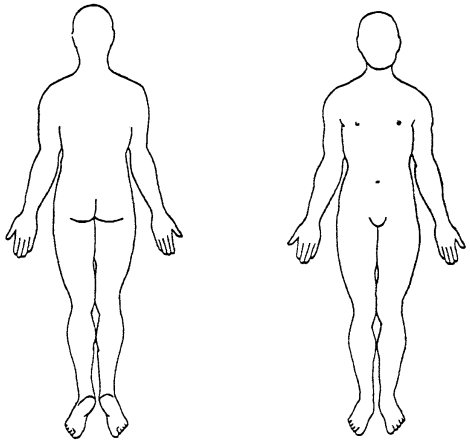
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____