

# Welcome to Healing Motion Physical Therapy!

To help you understand our policies, please read the following guidelines:

## Appointments

Attendance at all scheduled appointments is important. Our appointments are on a 45 – 60 minute basis. If you are late for your appointment, your therapist may feel it necessary to do only a portion of your treatment, or reschedule for another day. If a scheduling conflict occurs, please call us at 541-929-2255 as soon as possible. We may be able to use your time for another patient and reschedule you for a more convenient time.

## No Show or Cancellation Appointments

I understand that the primary responsibility for attending appointments that are scheduled is mine. A reminder card will be given when each appointment is scheduled. If a no show or cancellation occurs you will be billed at the following rate:

\_\_\_\_\_ **No show:** If you do not come to a scheduled appointment you will be billed **\$50.**  
Initial

\_\_\_\_\_ **Cancellation:** Because treatment space is tightly scheduled and therapist time is limited, cancellation at least 24 hours in advance is requested. If you call with less than 24 hours notice to cancel you will be billed: **\$30.**  
Initial

## Attire

Please wear or bring comfortable clothing which exposes the area that we are treating. For example, short sleeve shirt, tank top or shorts.

## Co-Payments

Please be aware of your insurance benefits and be prepared to pay any co-payments you may have each time you come to our office.

## 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, Inc. which are not covered expenses 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. Regardless of any insurance claims, full payment is due in less than 60 days.

By signing, I acknowledge that I have read and understand the above policies and procedures.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# Healing Motion Physical Therapy Patient Information Form

Date 1<sup>st</sup> visit: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Patient Name: (last, first) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State and Zip code

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Primary Insurance Plan: \_\_\_\_\_

ID/Policy #: \_\_\_\_\_

If subscriber is different from patient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
Address Home phone Date of birth Soc Security #

Secondary insurance plan: \_\_\_\_\_  
Insurance name ID# Policy #

If this condition is work or auto accident related:

Insurance carrier: \_\_\_\_\_ Case/claim #: \_\_\_\_\_

Contact information for insurance carrier:

\_\_\_\_\_  
Contact name Address Phone

## Emergency Contract Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Who may we thank for referring you here? \_\_\_\_\_

**HEALING MOTION PHYSICAL THERAPY  
PATIENT ACKNOWLEDGEMENT AND CONSENT**

I understand and agree that Healing Motion Physical Therapy my 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 insurance companies or others who may be responsible to pay for some or all of my health care and
- 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 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 any revised Notice of Privacy Practices. I also understand that 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.

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

By: \_\_\_\_\_  
Patient or authorized representative

Date: \_\_\_\_\_

# Healing Motion Physical Therapy

## Health Questionnaire

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0 = Pain Free

1 = Very minor annoyance - occasional minor twinges. No medication needed.

2 = Minor Annoyance - occasional strong twinges. No medication needed

3 = Annoying enough to be distracting. Mild painkillers take care of it. (Aspirin, Ibuprofen)

4 = Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.

5 = Can't be ignored for more than 30 minutes. Mild painkillers ameliorate pain for 3-4 hours.

6 = Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (Codeine, narcotics) reduce pain for 3-4 hours.

7 = Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.

8 = Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.

9 = Unable to speak. Crying out or moaning uncontrollably - near delirium.

10 = Unconscious. Pain makes you pass out.

### PAST OR CURRENT MEDICAL PROBLEMS (PLEASE CIRCLE):

High blood pressure	Heart failure	Heart disease	Pneumonia
Asthma	Allergies	Hay fever	Chronic sinusitis
COPD/ Emphysema	Tuberculosis	Diabetes	Hepatitis
High cholesterol	Thyroid disorder	Heartburn	Cancer
Anemia	Blood transfusion	Blood disorder	HIV/AIDS
Stroke	Panic attacks	Anxiety	Depression
Arthritis	Bone fracture	Migraines	Seizures
Rheumatoid arthritis	Kidney or bladder disease or infection	Stomach/intestinal problems	Breast/ovarian/uterine problem
Other:			

### SURGERIES AND APPROXIMATE DATES (month/year):

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

### Please list current medications you are currently using:

\_\_\_\_\_  
 \_\_\_\_\_

### Have you ever had or do you currently have any of the following conditions:

Ligament damage       Strain/Sprain       Patella-femoral pain  
 Subluxation/Dislocation       Bursitis       Tendinitis  
 Cartilage damage/removal       Carpal Tunnel       Rotator cuff disorder  
 Fracture       Muscle spasm       Scoliosis  
 Ruptured/Herniated disc       Osteoporosis       Chronic low back pain  
 Other

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