MotionWorks physical therapy

Patient Intake Form

PATIENT INFORMATION

Name (First, MI, Last) MR MISS MRS MS DR _____

Nickname you would prefer _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Gender (please circle) M F

Email Address _____ Marital status (please circle) S M D W

Date of Birth _____ Age _____ Next MD visit _____

Injured Area _____ Onset Date of Injury/Surgery _____

Employer/School _____ Occupation _____

City _____ State _____ Zip _____

How can we remind you of your appointment(s)? Home phone call Cell phone call Text

PHYSICIAN/REFFERRING PROVIDER INFORMATION

Referring Physician _____ Phone _____

Address _____

City _____ State _____ Zip _____

Primary Care Physician _____ Phone _____

Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Relationship _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____

Name of Policy Holder _____ Relationship _____

Date of Birth_____

Insurance Phone _____ ID # _____ Group # _____

Secondary Insurance Company _____

Name of Policy Holder _____ Relationship _____

Date of Birth_____

Insurance Phone _____ ID # _____ Group # _____

HIPAA AUTHORIZATION

In compliance with HIPAA regulations, I authorize the following individual(s) to receive verbal information regarding the billing of my account.

_____ _____

Name/Relationship Name/Relationship

OTHER

How did you hear about MotionWorks Physical Therapy? (Please circle)

Physician	Newspaper	Family	Coach
Online search	Friend/Co-worker	School	Informational Seminar
Website	Injury Screening	Facebook/Twitter	Other: _____

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WORKER'S COMPENSATION

Were you injured at work? YES NO Date of Injury _____

Employer Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

W/C Carrier Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

W/C claim # _____

W/C case manager name _____ Phone _____

MOTOR VEHICLE ACCIDENT (MVA)

Were you injured as the result of a MVA? YES NO Date of Injury _____

Are you working with an attorney? If so, please list name of firm _____

Attorney Name _____ Attorney Phone _____

Address _____

City _____ State _____ Zip _____

TREATMENT OF MINORS

Responsible Party _____ Relationship to Minor _____

Address_____ Date of Birth_____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Other Phone _____

Email Address _____ Gender (please circle) M F

Marital status (please circle) S M D W

Employer _____ Occupation _____

FINANCIAL POLICY AUTHORIZATION

- Any co-pays are due on the day the service is delivered.
- Due to changes related to the Affordable Care Act, patients with no co-pay, high deductible insurance plans ($2,000 or greater) and with unmet deductibles will be charged a $20 fee that will be applied toward their out-of-pocket amount due for therapy services; the $20 fee will be collected each day that services are delivered.
- As a courtesy to our patients, we will verify your insurance coverage and benefits, file claims on your behalf based on the information you have provided, and will submit any additional information required by your insurance company.
- I request that payment of authorized benefits be made to MotionWorks Physical Therapy for any services provided to me. I authorize release of any medical and/or patient information needed to determine benefits for related services to any insurance company, any other third party payer, state medical assistance program, and /or any other governmental payer responsible for paying such benefits.
- I agree to pay for all remaining balances and charges not covered. I authorize a copy of this authorization to be used in place of the original.

INFORMED CONSENT FOR TREATMENT AUTHORIZATION

- My signature below authorizes the staff of MotionWorks Physical Therapy to provide examination and treatment that is necessary for the injury/diagnosis for which I am here, OR for the consent to examine and treat a minor for which I am the responsible parent/guardian. Name of Minor:_____
- I agree to communicate any discomfort during treatment with my provider. I will also recognize my right to stop testing or treatment if the pain becomes more than I can tolerate, or if I feel I am over-exerting myself due to other issues related to my heart, lungs, or general medical condition. I also agree to ask any questions and relate any concerns that I have at any time to my provider or other staff at MotionWorks Physical Therapy.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Name of Patient/Patient Representative (Print) Date