Health in Motion
physical therapy + wellness

Welcome to Health in Motion Physical Therapy!

Thank you for trusting us with your health and wellness needs. We know you have the choice to go wherever you want, so we appreciate you choosing our clinic.

Your first appointment includes an initial evaluation. Your physical therapist will assess your individual needs and develop a treatment plan to meet your physical therapy goals. Your P.T. will discuss how often he/she recommends you schedule treatment until those goals are met. We recommend patients wear comfortable, loose clothing and shoes that are easy to take on/off.

As a courtesy, we'd be happy to bill your insurance provided they fall within the participating insurances listed below. Most insurance companies require a physician referral in order to pay for physical therapy so make sure you check with your individual plan. Co-pays, co-insurance, and deductibles are collected at the time of service. Patients without insurance are required to pay in full at the time of service. We accept cash, check, VISA, and MasterCard.

Participating Insurance Companies:
Aetna/Health Info Net/First Choice Health
Allegiance/Cigna
Auto Insurances (related to Motor Vehicle Accidents)
Blue Cross Blue Shield
Medicare/BCBS Medicare Advantage/Medicare Supplement
Montana Health Co-op
Pacific Source
Tricare
Workman's Compensation

Items to bring to your appointment:
Completed Registration Forms
Physician Referral
Photo ID and Insurance Card(s)
Medication/Supplement List (including dosages and frequency)

Medicare patients only – Number of physical and speech therapy visits this calendar year & where you attended therapy

Health in Motion Physical Therapy + Wellness Patient Information Minor

First Name: MI: Last Name:

Address: City State Zip

Birth Date: Age Gender SSN

Reason for visit? Referral: Last Physician Visit:

Parent/Guardian's Name: Parent/Guardian's Date of Birth:

Parent/Guardian's Phone: (Primary) (Work) (Other)

Parent/Guardian's SSN: Parent/Guardian's Employer:

Email address:

2nd Parent/Guardian's Name: 2nd Parent/Guardian's Date of Birth:

2nd Parent/Guardian's Phone: (Primary) (Work) (Other)

2nd Parent/Guardian's SSN: 2nd Parent/Guardian's Employer:

Emergency Contact: Relationship: Phone:

Alternative Emergency Contact: Relationship: Phone:

How did you hear about Health In Motion? ☐ Friend ☐ Doctor ☐ Search Engine ☐ Facebook ☐ Web Site ☐ Other

INSURANCE INFORMATION

(WE REQUIRE A COPY OF ALL INSURANCE CARDS AND PHOTO ID AT TIME OF SERVICE)

Although we are preferred providers with most insurance companies in Montana, it is possible that your individual plan may or may not cover our services. It is the patient's responsibility to call your insurance company prior to services to understand your plan's coverage.

☐ **PRIVATE INSURANCE** Primary:_____ Policy Holder:_____

Secondary:_____ Policy Holder:_____

or ☐ **SELF-PAY**

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to Health In Motion PT and for HIMPT to release any information required by the insurer for said payments. **I am financially responsible for non-covered services and for providing current insurance information.** I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account. Supplies are considered a "cash" sale and will not be billed to insurance. I understand that co-payment will be due at the time of service. We will provide you with a detailed receipt to use for flex account, tax purposes or possible insurance payers. A detailed explanation of the advanced beneficiary notice is available at the front office. HIMPT has the right to accept photographs and to take photographs, videotape or digital recordings of me and use these exclusively for the purpose of my care. I authorize HIMPT to access any part of my records from my physician's office for continuity of care and/or for the adjudication of all claims relating to payment of services. My medical records will be held in strict confidence and will not be released to any other party without my expressed written authorization. I hereby consent to receive physical therapy treatment at HIMPT starting today and terminating when determined by myself, my physician, or my physical therapist. I have read this information and understand its content.

Signature: **Date:**

Billing and Payment Policy

1. Patients are responsible for payment in full of all charges (including all past due and current balances and interest on balances over 90 days), regardless of insurance coverage.

2. HIMPT will bill insurance companies on behalf of our patients. It is the responsibility of the patient to know the policies and provisions of their individual insurance plan, and to **understand that there is no guarantee of payment.**

3. Copayments, deductible and coinsurance amounts are estimated by HIMPT based on information provided by patients' insurance plan, and are due at the time of service. Unless prior arrangements have been made with HIMPT

4. Unpaid balances exceeding ninety (90) days become patient responsibility, even when insurance claims are pending, unless other arrangements are made with HIMPT. After ninety (90) days, accounts will be subject to a monthly finance charge of 1.5% on outstanding balances until paid in full.

5. VISA, MASTERCARD, CASH AND/ OR CHECK can be used for payment on patient accounts. A $ 30.00 charge will be applied to all returned checks.

6. In the event legal action should become necessary to collect an unpaid balance due for services rendered, patient will be responsible for all finance charges, collection fees, and court costs in addition to the outstanding balance.

7. 24 hour notice is *REQUIRED* with cancellation of appointments. Without sufficient notice we are not able to offer the appointment to other patients that may be waiting to get in. Our system does send out text, voice or email appointment reminders as a courtesy. However, we do recommend that patients do not solely rely on these reminders. Late cancellations and no show fees in the amount of $75.00 will be assessed per incident. . If *UNPAID* these charges/fees *will* be sent to collections and all fees and costs of the collection will apply.

8. After **3 *No Shows,*** patient will be discharged from HIMPT.

9. Patients that are more than 15 minutes late for an appointment will be charged a $25.00 fee. Your appointment time is reserved for you. Time that you are not here cannot be billed to insurance and therefore increases clinic and patient costs. These charges are payable by patient in addition to copays or co-insurance deemed patient responsibility by patients insurance company.

By signing this document I attest that I fully understand and agree to all terms listed above.

_____ _____

Patient Name Date

_____ _____

Signature of responsible party Relation to patient

Patient Name: DOB:

Medical Information

Injury, onset or change of status Date:_____Have you experienced similar symptoms in the past? Yes No

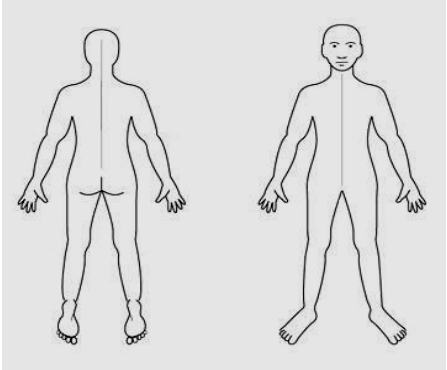
Primary Concern/Chief Complaint:_____

Are your symptoms due to a new injury? Y N **How did you become injured?**_____

_____

Previous surgery or hospitalization for this injury? (Please list)_____

On the diagram below please indicate where you are experiencing <u>Pain/discomfort</u> with *XXX*
<u>Numbness/tingling</u> with ///



PAIN SCALE 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

NO Discomfort — WORST PAIN IMAGINABLE

Based on the pain scale above, please indicate what number your pain is at when;

Best_____ Current_____ Worst_____

Please check any of the following that cause your symptoms to worsen.

☐ Sitting ☐ Standing ☐ Walking ☐ Stairs-up ☐ Stairs-down
☐ Bending ☐ Voiding ☐ Lying Down ☐ Cough/sneeze ☐ Sit to stand

What improves your symptoms? ☐ Ice ☐ Heat ☐ Medication ☐ Other_____

Nature of Symptoms/Pain You Are Currently Experiencing (*circle all that apply)*

Sharp Shooting Dull Ache Burning Tightness Throbbing

Frequency of Symptoms. Please circle the option below that best describes how often you are experiencing symptoms

Constant (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Patient Name: DOB:

MEDICAL INFORMATION

What is your occupation?_____**Tobacco user/smoker?** Yes No

Have you had any falls in the last year? Yes No **If yes, how many?**_____ **Were there any injuries with the falls?** Yes No

Please check any of the following symptoms you are currently experiencing that are new or unusual.

☐ Unexplained weight loss/gain	☐ Memory Issues	☐ Weakness
☐ Nausea/vomiting	☐ Dizziness	☐ Vision Problems
☐ Leakage with activity	☐ Difficulty Swallowing	☐ Insomnia
☐ Loss of bowel/bladder control	☐ Swelling	☐ Fatigue

Are you, or have you ever been treated for any of the following? (Check all that apply)

☐ Heart Disease	☐ Fractures	☐ Osteoarthritis	☐ Kidney Issues
☐ Stroke	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Thyroid Issues
☐ Diabetes	☐ Cancer	☐ Rheumatoid Arthritis	☐ Depression
☐ Fibromyalgia	☐ Obesity	☐ Traumatic Brain Injury	☐ Asthma

How much caffeine do you consume daily?_____ **Do you drink alcohol?** Yes No

Are you allergic to latex? Yes No **Are you allergic to beeswax?** Yes No **Are you allergic to Coconut oil?** Yes No

Any other allergies? If yes please list_____

Are you taking blood thinners or aspirin? Yes No **Do you have a pacemaker?** Yes No **Are you pregnant**? Yes No

Do you have an intra-uterine device (IUD)? Yes No **Do you have a DNR order in place?** Yes No

Please list any previous surgeries and the dates when they occurred._____

_____

List of medications including prescription, over-the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements

Medications	Dosage	Frequency	Route of Admin: (oral, topical, etc)	Changes (Office Use)	Date of Changes (Office Use)

Patient Name: DOB:

Medical Information

How would you rate your general health? *(Circle one)* Good Fair Poor

Home Layout: *(Check all that apply)*

- ☐ 1-story
- ☐ 2 - story
- ☐ Apartment/condo
- ☐ Wheelchair accessible
- ☐ Stairs/step
- ☐ Shower stall
- ☐ Bath/shower combo

Social History: *(Circle one)* Married Single Divorced Widowed

Living arrangements: *(Circle one)* Lives alone Lives with family Lives with caregiver Lives at assisted living facility

Health in Motion Physical Therapy Inc.
3985 Valley Commons Drive Bozeman, MT 59718
Phone: (406) 585-4642 Fax: (406) 585-2878

Patient Name:_____
(Last) (First) (MI)

DOB:_____ SS#:_____

AUTHORIZATION FOR RELEASE OF INFORMATION
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

☐ Discharge Summary
☐ Mental Health Assessment
☐ Physician Orders
☐ General Progress in Treatment
☐ Continued Stay Reviews
☐ Continued Care Plan
☐ History & Physical
☐ Treatment Plan
☐ Dates in program
☐ Discharge Criteria
☐ Correspondence (Letters)
☐ Admission Notes
☐ Progress Notes
☐ Medication Records
☐ Interdisciplinary Notes

Date Release Revoked:

☐ Other (Please be specific) _____

Purpose of need for disclosure is _____

Permission is hereby given to EXCHANGE information with:

Health in Motion Physical Therapy
3985 Valley Commons Drive
Bozeman, MT 59718

AND

_____
_____
_____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is **NOT** sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility named to disclose such information as herein contained. I understand that I may revoke or cancel this authorization at any time. Withdrawal of the authorization does not affect any information disclosed before providing a written notice of such a withdrawal of authorization. **This authorization will remain in effect for 180 days in order to carry out the purpose for which my permission was given.** I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see this information. A photocopy of this authorization is as valid as the original.

_____ _____
Patient Signature Date Facility Witness Signature Date

_____

(☐) I Cancel My Permission To Disclose The Information Described On This Form.

_____ _____
Patient Signature Date Facility Witness Signature Date

This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules and laws restrict any use of the information to criminally investigate of prosecute any alcohol or drug abuse patient.

HEALTH IN MOTION PHYSICAL THERAPY HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information:
  (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify_____
    _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date