JOINTS IN MOTION
PHYSICAL THERAPY & WELLNESS

INTAKE FORM

***Thank you for choosing Joints in Motion Physical Therapy and Wellness! To best serve you, we require the following information. Please print, all information will be confidential.

Patient Information

Patient Name:_____ D.O.B:_____
Address: _____ City:_____
State:____ Zip Code:_____ ☐ Male ☐ Woman Social Sec#: ___-__-____
Home Phone: _____ Alternate Phone (Cell, Work): _____
E-mail:_____ ☐ Single ☐ Married ☐ Minor
How would you like to be reminded about your follow up appointments?
☐ Text Message ☐ Email
How did you hear about our clinic?
☐ Dr. ☐ Insurance ☐ Family/Friend ☐ Former Patient ☐ Yellow Pages ☐ Internet ☐ Fitness Club ☐ Other
Is there a specific individual we can thank for your referral? _____

Work Information

Occupation:_____ Employer:_____

In Case of Emergency

Name of Local Friend or Relative:_____ Relationship:_____
Emergency Contact's Phone #:_____

Care Provider Information:

Referring Dr.:_____ Regular Dr./PCP:_____

Insurance Information (Please give your insurance card to front desk):

Primary Insurance Name:_____
Subscriber's Name (if different):_____
ID #: _____ Group/Policy #:_____
Patient Relationship to Subscriber: ☐ self ☐ spouse ☐ child ☐ other
Secondary Insurance:_____
Subscriber's Name:_____
ID #: _____ Group/Policy #:_____
Patient Relationship to Subscriber: ☐ self ☐ spouse ☐ child ☐ other

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Attorney Information:

Name:_____ Law Firm:_____ Phone #_____

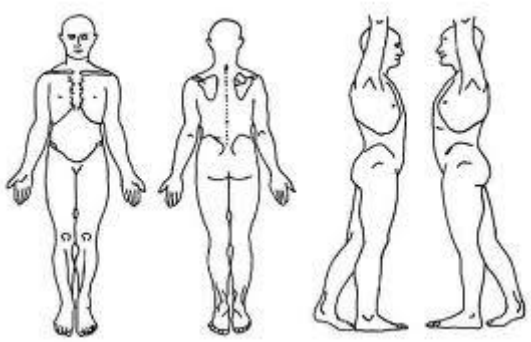
Address:_____ City:_____ State:____ Zip:_____

JOINTS IN MOTION
PHYSICAL THERAPY & WELLNESS

Patient Medical History

Chief Complaint (body part)_____ Date of Onset_____

Please indicate where your pain or symptoms are by shading areas below



Description of Injury:_____

Diagnostic Tests: ☐ Nerve Conduction Velocity ☐ EMG ☐ Bone Scan ☐ MRI ☐ Cardiac Stress Test ☐ CT scan ☐ Doppler Studies ☐ X-rays ☐ Other_____

Height _____ Weight_____

Medications (List all prescription and nonprescription):_____

_____

Previous Surgeries (Please provide dates)_____

_____

Current Conditions-Please check any problems you have had in the past 12 months

☐chest pain/angina	☐convulsions/ seizures	☐nausea/vomiting	☐depression
☐palpitations	☐balance/coordination	☐urinary problems	☐memory loss
☐shortness of breath	☐joint pain/stiffness	☐bowel problems	☐confusion
☐wheezing	☐swelling in joints	☐eyes/vision	☐nervousness/anxiety
☐chronic/frequent cough	☐muscle pain or cramps	☐ears/hearing	☐difficulty sleeping
☐fever/sweats/chill	☐muscle weakness	☐nose/mouth/throat	☐sexual difficulty
☐headaches	☐numbness or tingling	☐skin rash	☐male-prostate
☐excessive fatigue	☐weight loss/gain	☐Infections	☐female-menstrual
☐dizziness	☐loss of appetite	☐bleeding/bruising	☐other condition

Medical History-Please check if you have had the following:

☐spine injury	☐stroke	☐kidney problems	☐diabetes
☐back trouble	☐heart problems	☐bladder problems	☐AIDS or HIV (+)
☐arthritis	☐circulation problem	☐stomach problem	☐migraine headaches
☐osteoporosis	☐respiratory problems	☐eye disease	☐low blood pressure
☐high blood pressure	☐skin disease	☐hepatitis	☐epilepsy
☐asthma/allergies	☐recurring infection		

other_____

Please provide details regarding conditions checked above:_____

_____

Have you received Physical, Occupational, or Speech Therapy in the last Year? Circle: Yes or NO

If yes, when, where, and what was the duration: _____

_____

CONSENT FOR CARE and TREATMENT: I the undersigned, do hereby agree and give consent for Joints in Motion Physical Therapy and Wellness, LLC to furnish physical therapy and wellness care and treatment to me (or my child) considered necessary and proper in diagnosing or treating my (or his/her) condition

_____ _____ _____

Patient or Guardian (print) **Patient or Guardian (signature)** **Date**

_____ _____

Signature of physical therapist Date

Policies

Payment Policy:

Thank you again for choosing us as your physical therapy provider. Our goal is to provide the highest level of physical therapy and wellness possible for each and every patient we see. In return we do ask that each patient accept responsibility for paying the fees for his or her treatment. Patients are responsible for their co-insurance /co-payment/deductible **at the time services are rendered.** Payment may be made by check, Visa, MasterCard, or in cash.

Prior to beginning treatment we will verify your insurance benefits. While we take all reasonable action to provide accurate therapy benefit information for you specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier.

PRIMARY INSURANCE-Joints in Motion Physical Therapy and Wellness will bill your primary insurance as a courtesy to you. Any remaining balance after your co-pay and your primary coverage has been paid including items classified as "above usual and customary" is due from you upon receipt of the explanation of benefits from your primary insurance carrier. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved.

MEDICARE- Joints in Motion Physical Therapy and Wellness will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will be your secondary insurance for you if you have one or the balance will be billed to you.

SELFPAY- Please pay the balance in full at the time of service or upon receipt of a monthly statement. If you are unable to pay the balance in full we are willing to arrange suitable payment arrangements.

WORKERS'COMP- Joints in Motion Physical Therapy and Wellness will bill your workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

_____ Please Initial

Cancellation Policy:

Joints in Motion Physical Therapy and Wellness requires **at least 24 hours advance** notice be provided for all cancelled appointments. If you fail to provide adequate notice for you cancellation, you will be charged a $30 missed appointment fee. By signing below you acknowledge that you understand this cancellation policy and agree to give sufficient notice on all cancelled appointments or pay the missed appointment fee.

_____ Please Initial

HIPPA Policy:

I understand and have been offered a copy of the Private Practice Policy that provides a complete description of information uses and disclosures. I understand that Joints in Motion reserves the right to change their policy and will post a copy of any revisions to the Private Practice Policy.

_____ Please Initial

Patients Rights
Access:

You have the right to view or obtain copies of your health information including all correspondence to your referring physician. Joints in Motion will provide you with a copy of your initial evaluation that includes the plan of care for your treatment. All other information is available upon your request.

_____ Please Initial

Billing Office:

Statements will be sent to you by our contracted billing office (Medical Billing Company of the South). If you have questions regarding your bill please contact them at 866-679-1600.

Assignment of Benefits:

I authorize payment otherwise payable to me to go directly to Joints in Motion Physical Therapy and Wellness for all services rendered to include all insurance carriers and third party liabilities. I understand that I am ultimately responsible for all charges not covered by my insurance.

Signature:_____ Date:_____

(Name of Responsible party if minor)_____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Joints in Motion Physical Therapy and Wellness,LLC's LEGAL DUTY

_ Joints in Motion Physical Therapy and Wellness,LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USE AND DISCLOSURES OF HEALTH INFORMATION

Joints in Motion Physical Therapy and Wellness, LLC_ uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Joints in Motion Physical Therapy and Wellness, LLC_ may* use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

*Joints in Motion Physical Therapy and Wellness, LLC_* may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation *Joints in Motion Physical Therapy and Wellness, LLC's_* policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

*Joints in Motion Physical Therapy and Wellness, LLC_* may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practice at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, When required by law or in emergency circumstances. *Joints in Motion Physical Therapy and Wellness, LLC_* will consider all such requests on a case by case basis, but the practice is not legally required to accept the.

CONCERNS AND COMPLAINTS

If you are concerned that *_Joints in Motion Physical Therapy and Wellness, LLC_* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on *Joints in Motion Physical Therapy and Wellness, LLC_* health information practices or if you have a complaint, please contact the following person:

Joints in Motion Physical Therapy and Wellness, LLC
Scott Adam Smith, PT, OCS

214 Saint James Ave 140B, Goose Creek, SC 29456
Telephone: Practice (843) 793-4466 Fax: Practice (843) 793-3786

Joints in Motion Physical Therapy and Wellness, LLC

Patient Information acknowledgement form

I have read and fully understand *Joints in Motion Pl1vsical Tlterapv and Wellness. LLC*'s Notice of Information Practices. I understand that *Joints in Motion Physical Therapy and Wellness, LLC* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if l notify the practice. I also understand that Joints in Motion Physical Therapy and Wellness, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in *Joints in Motion Phvsical Therapv and Wellness.LLC* 's Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I also authorize *Joints in Motion Pl1vsical Therapv and Wellness, LLC* to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____

Date

*Joints in Motion Physical Therapy and Wellness, LLC_*

Designated individuals authorization form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Patient Name

_____

Patient Signature

_____

Date