Patient Information and Medical History

Vertical Motion Physical Therapy

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ Home Phone: _____

Email: _____ Mobile Phone: _____

Emergency Contact/Phone: _____ Preferred Contact: ☐ Home ☐ Mobile

Do you wish to receive appointment reminders via Email? ☐ Yes ☐ No

REFERRAL INFORMATION:

I was referred by: ☐ Physician ☐ Friend ☐ Self-Referred ☐ Other: _____

Referring Physician: _____ Phone: _____

Diagnosis: _____ Fax: _____

Have you had any diagnostic testing for this injury/condition? Please list: _____

MEDICAL HISTORY:

Are you currently taking any prescription or non-prescription medication? ☐ Yes ☐ No

List all medications you are currently taking: _____

_____

Are you allergic to: Medication Latex Adhesive

List all allergies: _____

Family History: Cancer High Cholesterol Diabetes Heart Attack High Blood Pressure

Have you EVER been diagnosed as having any of the following conditions? Please check the appropriate box.

Cancer (type_____)-☐
Shortness of Breath-------- ☐
Chest Pain (Angina) -------- ☐
Night Sweats---------- ☐
Weight Loss----------☐
High Blood Pressure-------- ☐
Coronary Artery Disease---☐
Heart Attack---------- ☐
Blood Clots (DVT)----------☐
Stroke or TIA----------☐
Pacemaker---------- ☐
Irregular Heartbeat--------- ☐
Anemia----------☐
Ulcer/Stomach Problems--☐
Diabetes---------- ☐
Vision/Hearing Problems--☐
Thyroid Disease----------☐
Fatigue---------- ☐
Depression---------- ☐

Emotional/Psychological----- ☐
Bowel/Bladder Problems-----☐
Numbness/Tingling---------- ☐
Joint Replacement---------- ☐
Pins or Metal Implants-------- ☐
Foot/Ankle Injury/Surgery--- ☐
Knee Injury/Surgery---------- ☐
Shoulder Injury/Surgery------ ☐
Neck Injury/Surgery---------- ☐
Hepatitis (Type ___)---------- ☐
Kidney Disease---------- ☐
Urinary Incontinence---------- ☐
Varicose Veins---------- ☐
Osteopenia---------- ☐
Osteoporosis---------- ☐
Bone or Joint Infection--------☐
Headaches/Migraines--------- ☐
Epilepsy/Seizure---------- ☐
Gout---------- ☐

Weakness---------- ☐
Do you smoke:
Yes-☐ No-☐
Are you pregnant?
Yes-☐ (____months) No-☐
Have you recently given birth?
Yes-☐ (Date_____) No-☐
Chemical Dependency-------- ☐
Eating Disorder---------- ☐
Anxiety/Panic Attacks---------☐
Asthma/Breathing Diff-------- ☐
Pneumonia----------☐
HIV/AIDS----------☐

Other Illnesses diagnosed by a Physician (Please List) _____

_____

_____

Functional Activity and Pain Assessment

Vertical Motion Physical Therapy

Patient Name: _____ Today's Date: _____

Briefly describe your symptoms: _____

How did your symptoms start? _____

Symptoms began on: _____

Did you receive surgery for this problem? ☐ Yes ☐No If Yes, Date of Surgery: _____

Type of Surgery: _____ Name of Surgeon: _____

How many minutes can you perform the following activities comfortably? ☐ Sitting _____

☐ Standing _____

☐ Walking _____

Which of these activities causes you difficulty or discomfort because of your injury?

☐ Sitting	☐ Combing hair	☐ Cleaning tub
☐ Standing	☐ Brushing teeth	☐ Making bed
☐ Walking	☐ Dressing self	☐ Dusting
☐ Going up stairs	☐ Putting on shoes/socks	☐ Doing dishes
☐ Going down stairs	☐ Sleeping	☐ Cooking
☐ Reaching	☐ Bathing	☐ Gardening
☐ Reaching overhead	☐ Driving	☐ Mowing
☐ Lifting	☐ Vacuuming	☐ Snow shoveling
☐ Carrying	☐ Laundry	

Are there any recreational activities you are not doing now because of your injury? _____

_____

Pain Rating

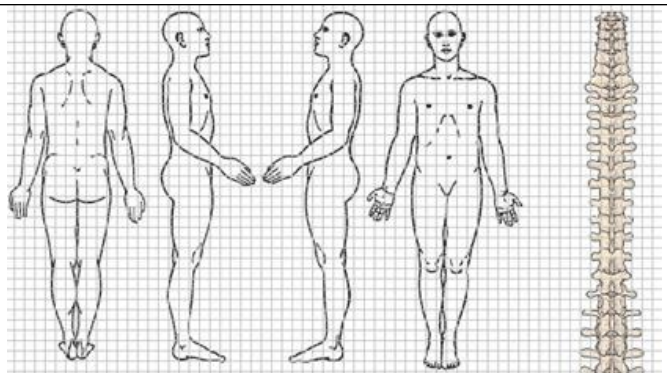
Are you experiencing: ☐ Pain ☐ Tingling ☐ Numbness ☐ Stiffness

Average pain intensity over the last <u>24 hours</u>:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme pain)

Average pain intensity over the past <u>week</u>:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme pain)



Mark the areas where you feel the described sensations on your body using the appropriate symbol. Mark areas of radiation. Include all affected areas related to your current problem.

Pain XXXX Numbness ==== Tingling ####

How often do you experience your symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

How much have your symptoms interfered with your usual daily activities? (Both outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, would you say your overall health right now is… ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Financial and Insurance Policy

Vertical Motion Physical Therapy, LLC

Insurance Benefits: It is the patient/guardian's responsibility to understand your insurance policy, as it is a contract between you and your insurance. As a courtesy to our patients, our office will call your insurance to obtain an estimate of your benefits. The coverage a patient will receive depends upon the quality of your chosen plan and an **estimate** that we provide you is based on the information we have received from your insurance company. It is not an authorization for your treatment, nor is it a guarantee of payment by your insurance company. Patients/guardians are responsible for paying all charges not covered by their insurance plans, including all fees considered above the insurance policy's usual and customary fee schedule. As the patient/guardian, you will be responsible for all costs regardless of what your insurance company determines usual and customary. **It is the insured's responsibility to know his/her insurance coverage for services provided at Vertical Motion Physical Therapy.** We encourage all patients to call their insurance companies as well to verify benefits.

Visit Limits: Some insurance plans have limits on the number of physical therapy visits that are covered during the plan year. It is the patient/guardian's responsibility to know what limits the insurance policy imposes, and how many visits have been used to date. Visits that exceed the allowed amount will be charged at our *Self Pay* rate, which is **$85 per visit**.

Credit Card Policy: I acknowledge that my credit card will be run automatically, at the time of service, for copays, coinsurance, deductible, or purchased supplies. Unpaid balances under $500 will be automatically charged. If your balance is over $500 will be notify you prior to running the card.

Claims Submission: VMPT will submit a claim up to **two times** per appointment and follow up with claims not paid within 30 days. Further insurance appeals become the responsibility of the patient/guardian. Patients/guardians are responsible for insurance balances not paid within 60 days and unpaid balances will incur a $10.00 monthly rebilling charge. It is VMPT's office policy that balances will not be carried longer than 90 days. If you have not made payment arrangements with VMPT we will refer your account to a collections agency. The patient/guardian authorizes VMPT to pass the necessary information for the purposes of collecting an outstanding balance. In the event that your balance is passed to collections, the patient/guardian agrees to pay VMPT an additional 50% of the balance due to offset the collections cost.

Cancellation Policy: We require *24 hours' notice by telephone* for appointment cancellations. *Cancellations without Notice* (less than 24 hours) and *No Shows* will be assessed a No Show fee of **$40**. Exceptions will be made for illness (limit two times) and extreme weather only. Per Medicaid guidelines, **patients with only Medicaid** coverage cannot be charged a late cancel/no show fee. As a courtesy to our patients who are waiting for an appointment, our policy for Medicaid-only patients is to discontinue care should there be more than one no-show due to lack of patient compliance.

Supply Charges: Taping and Dry Needling are services we provide for which supplies *are not* covered by insurance and the patient is responsible for related supply charges. Taping fees are a **one-time $10** charge per body part. Dry Needling fees are **$20 per session**. Other supply charges may be assessed case-by-case.

I acknowledge that I have read and accept the above conditions.

_____ _____

Patient/Guardian Signature Date

Patient's Printed Name: _____

HIPPA Privacy Practices

Vertical Motion Physical Therapy

I have read and consent to the assumption of risk and release and the HIPAA practices adopted by Vertical Motion Physical Therapy. I understand that non-identifying patient data may be used in research and/or publication and consent to such use. I understand that I may obtain a paper copy of the VMPT Privacy Practices at any time by asking at the Front Desk.

Patient/Guardian Signature _____ Date _____

Patient's Printed Name: _____

Consent and Liability

1. **Consent for Medical Care:** I consent to have Vertical Motion Physical Therapy and/or its affiliates provide the treatment and care considered necessary and proper in diagnosing or treating my physical and mental condition. I understand this consent may be revoked by me at any time.

2. **Release of Information and Assignment of Insurance Benefits:** I authorize Vertical Motion Physical Therapy, or its legal representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to Vertical Motion Physical Therapy for medical services rendered.

3. **Assumption of Risk and Release:** I hereby acknowledge the inherent danger and risks involved in my participation in physical therapy provided by Vertical Motion Physical Therapy. I warrant that, during the entire time I participate in physical therapy provided by Vertical Motion Physical Therapy, I will be covered at my own expense for all activities related to or arising out of such participation by a private medical and liability insurance policy.

   Understanding the above, I hereby covenant and agree that I assume all risks and responsibilities involved in participating in physical therapy through Vertical Motion Physical Therapy and waive, release, and forever discharge Vertical Motion Physical Therapy their owners, directors, officers, employees, agents, or any person acting on their behalf, from any and all claims, demands, liability, and damages relating to, arising out of, or resulting from my participation in physical therapy provided by Vertical Motion Physical Therapy.

   I also covenant and agree to indemnify, defend and hold harmless Vertical Motion Physical Therapy, their owners, directors, officers, employees, agents, or any person acting on their behalf, from any and all claims, demands, damages, and liabilities, including but not limited to claims for personal injury, death, and property damage, by whomsoever brought, relating to, arising out of or resulting from my participation in physical therapy provided by Vertical Motion Physical Therapy, their owners, directors, officers, employees, agents, or any person acting on their behalf. I also covenant and agree to reimburse Vertical Motion Physical Therapy for each of their attorneys' fees, costs and expenses in connection with the defense of any such claim or demand.

Patient/Guardian Signature _____ Date _____

Patient's Printed Name: _____