Patient Financial Terms

Please Read – IMPORTANT

Welcome to Restore Motion. We provide physical therapy services for a wide variety of medical problems. Your insurance company may require that treatment be rendered only upon a script from a physician, dentist, or podiatrist. This script should be provided to us on your initial visit to our clinic. These scripts are generally valid for one month unless otherwise stated.

Appointment Information

- Appointments will usually last 50 to 60 minutes.
- Please arrive promptly for each scheduled appointment. If you are more than 10 minutes late, your therapist's schedule may prevent you from being treated.
- If after two "No Show" events, you do not call to cancel and "no show" for your visit, we reserve the right to charge you the full session amount and cancel all subsequent visits.
- Restore Motion requires 24 hours notice of your cancellation of scheduled appointment and you may be financially responsible for later cancellations and missed appointments (no shows). We reserve the right to charge for time reserved without proper cancellation. The cancellation fee is $50.

We must emphasize that as medical providers, our relationship is with you. Payment can be in the form of cash, check or credit card.

Financial Agreement:

I understand and agree that I am financially responsible for full payment of my bill of services. ___Initial
I understand the cost of therapy is dependent upon duration of appointment: ___Initial

30 min: $112.50 45 min: $168.75 60 min: $225.00

I am authorizing Restore Motion to automatically charge my credit card for every Date of Service I receive from Restore Motion. ___Initial

Credit Card #: _____ Exp. Date: _____ CVV #: _____
Billing Address: _____

Restore Motion can assist by filing an insurance claim on your behalf for out-of-network reimbursement (if you are eligible for out of network benefits).

I understand the Restore Motion financial policy and responsibility for my account.

I execute this AGREEMENT as of the ___ day of _____, 2023.

_____ _____
Responsible Party Signature Witness Signature

_____ _____
Print Name of Responsible Party Witness Name Print

Consent for Evaluation and Treatment for Physical Therapy

I acknowledge and understand that I have been referred to **Restore Motion** for evaluation and treatment for a musculoskeletal dysfunction.

I understand that to evaluate my condition it may be necessary, initially, and periodically, to have my therapist perform a musculoskeletal examination. This evaluation will assess posture, skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, dry needling, and educational instruction.

I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment. I understand that no guarantees have been or can be provided regarding the success of therapy. I understand that if I fail to carry out the follow-up care, I do so at my own risk. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Restore Motion.

Patient Name: _____ Date of Birth: _____
(Please Print)

Email: _____ Phone: _____

Address: _____

Patient Signature: _____ Date: _____

Signature of Parent or Guardian (If applicable): _____

Parent/Guardian Date of Birth: _____

Witness Signature: _____

Use and Disclosure of Protected Health Information

Section I: Patient Acknowledgement

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Restore Motion, LLC may use and disclose protected health information about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions, but if we do, we are bound by our agreement with you.

Section II: Authorization for Use of Answering Machine and/or Voicemail

Restore Motion's physical therapists and administrative staff are routinely unable to contact patients directly during normal business hours. On these occasions, our office leaves messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication.

_____(Initial) Yes, I agree to allow Restore Motion, LLC's therapists and administrative staff to leave messages, including texts that include Protected Healthcare Information on the following communication devices ***(check all those that apply)***

☐ Home number ☐ Work number ☐ Cell number ☐ Email ☐ Text

_____(Initial) Yes, I give my permission to use my E-Mail address to be informed of Restore Motion with scheduling/invoices/news/events. (E-Mail address will not be shared to third parties.) I understand email is not a secure form of communication.

_____(Initial) No, I do not agree to allow Restore Motion, LLC's therapists and administrative staff to leave messages that include Protected Healthcare Information on my home, work and cell phones.

By signing below, you acknowledge that you have read our HIPPA Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Date

_____

Patient Signature

Intake Questionnaire

Name: _____ Date: _____
Occupation: _____
Referral from: _____
Primary MD: _____
Reason for Referral: _____
Date of onset: _____

List all activities that you cannot do because of your current problem: "current level of function":

_____
_____

What activities make your problem worse?

_____
_____

What function(s) do you hope to change by coming to therapy? What are your Goals?

_____
_____

History of Onset

When did this current episode of pain begin? _____
Did the pain/problem begin: ☐ Gradually ☐ Suddenly

How did this episode of pain begin?

☐ Bending ☐ Twisting ☐ Lifting ☐ Pushing/Pulling

☐ Motor Vehicle Accident Other _____

If your pain is due to an injury, briefly describe the events that led to the injury.

_____
_____

Have you had prior episodes of this pain/problem? Yes No

If yes, how many episodes have you had? _____
When did the first episode begin? _____
Is this episode worse than the previous episode? _____
Explain what caused the prior episodes: _____

Where are you experiencing your pain? (Check all that apply)

☐ Back ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle/foot

☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Wrist/Hand ☐ Pelvic Area

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Use the diagram and symbols to indicate where your pain is.

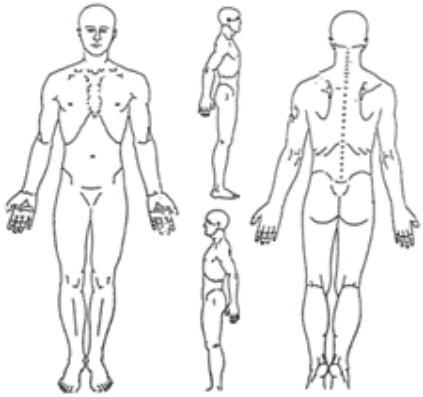
Ache: AAA

Burning: XXX

Numbness: OOO

Pins/Needles: …

Stabbing: ///



Please check the activities that affect the pain/problem.

	Better	Worse	No Change
Coughing	_____	_____	_____
Sneezing	_____	_____	_____
Straining	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Sitting	_____	_____	_____
Lifting	_____	_____	_____
Pushing/Pulling	_____	_____	_____
Driving	_____	_____	_____
Bending Forward	_____	_____	_____
Lying on Stomach	_____	_____	_____
Overhead Reaching	_____	_____	_____
Squatting	_____	_____	_____
Kneeling	_____	_____	_____
Typing/Writing	_____	_____	_____
Intercourse	_____	_____	_____

Please indicate the number that best represents your level of pain.

What is the WORST?

____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

What is it TODAY?

____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

What is the LEAST?

____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

Injury History: Include work or non-work injuries (fractures, major sprains, or injuries with no specific diagnosis):

_____

_____

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Medical History

If you had surgery for this or a different problem, complete the following for each operation.

Surgery Type	Date	Type of Improvement
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that apply to you.

_____ Rheumatoid Arthritis
_____ Osteoarthritis _____
_____ Diabetes Type I or 2
_____ Cancer _____
_____ Tuberculosis
_____ Stroke
_____ Sexually transmitted diseases or HIV/AIDS
_____ Hepatitis A, B, C
_____ Osteoporosis or Osteopenia
_____ Currently Pregnant or attempting pregnancy
_____ Thyroid Condition
_____ Liver disease
_____ Poor balance or recent falls
_____ Dizziness/vertigo/fainting/blackouts
_____ Severe headaches
_____ Gastrointestinal issues (IBS, Crohn's)
_____ Abdominal pain/bloating/gas
_____ Heartburn/GERD
_____ Gout
_____ Depression/Anxiety
_____ Psychological _____
_____ Chemical dependency (i.e. alcoholism or drugs)
_____ Food intolerance _____
_____ Other _____

_____ Congenital heart defect
_____ Heart problems/heart disease
_____ High or low Blood Pressure
_____ Pacemaker
_____ Chest pain/angina/palpitations
_____ Circulation problems or blood clots
_____ Bronchitis/pneumonia
_____ Emphysema
_____ Asthma
_____ Bleeding disorders
_____ Using blood thinners
_____ Toxoplasmosis
_____ Fibromyalgia
_____ Recurrent muscle/ joint pain
_____ kidney disease/stones
_____ Prostate problems
_____ Lyme disease, tick related diseases
_____ Multiple sclerosis
_____ Epilepsy/seizure disorders
_____ Anemia
_____ Latex Allergy
_____ Skin problems _____
_____ Menopause

Review of Systems: During the past year, have you had any of the following?

_____ Unexplained Fevers	_____ Chest Pain/Tightness	_____ Night Sweat	___ Trouble Breathing
_____ Excessive Fatigue	_____ Persistent Cough	_____ Hoarseness	___ Nodes (groin/armpit/neck)
_____ Stiffness in Joints	_____ Swollen Ankles/Legs	_____ Easy Bruising	___ Difficulty swallowing
_____ Black/Bloody Stool	_____ Urinary Incontinence	_____ Painful Urination	___ Blood in urine
_____ Change in appetite	_____ Change in Bowel Habits	_____ Difficulty Sleeping	___Joint Swelling/Warmth

_____ Change in menstruation _____ Unusual discharge from vagina/penis _____ Unexplained Weight Loss
_____ Unusual Stress in Work Life _____ Unusual Stress in Home Life

During the past month have you often been bothered by feeling down, depressed, or hopeless?
☐ Yes ☐ No

During the past month, have you often been bothered by little interest or pleasure in doing things?
☐ Yes ☐ No

Is this something with which you would like help?
☐ Yes ☐ Yes, but not today ☐ No

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Allergies (please list)

_____

_____

Which special tests performed have been performed regarding your current problem?

	Date	**What Area of Body/Results**
X-Rays		
Bone Scan		
MRI		
CAT Scan		
Myelogram		
EMG/NCS		
Cystoscopy		
Colonoscopy		
Epidural Steroid Injection		
Nerve Root Block		
Facet Joint Injection		
Urodynamics		
Other		

Medications:	**Type**	**Dosage**	**How long have you been on it?**

Developmental History: Note any development delays or the need for corrective bracing as child/teenager.

_____

_____

Therapy History

If you have had previous physical therapy/chiropractic/acupuncture in the past, please indicate where, when, and how long you attended: _____

_____

Personal History

Regular Exercise (what and how often) _____

Dietary Habits (caffeine, alcohol, citrus, nutrisweet, servings of fruits/vegetables, bread)

_____

Fluid Intake/Day _____

Sleep Habits (trouble falling asleep, staying asleep, reason for awakening, resting in am?)

_____

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Gender Related History: Please provide information on any of the following that apply to you

Males: Prostate/Testicular Problems?

Female Gynecological History:

Date of last pelvic exam: _____

Have your menstrual periods stopped? _____ Yes _____ No

On hormone replacement therapy? _____ Yes _____ No

If yes, which one? _____

Do/Did you have pain with intercourse? _____ Yes _____ No

Do/Did you have pain with menstrual periods? _____ Yes _____ No

_____ Endometriosis _____ Prolapse _____ Cysts _____ Fibroids _____Pelvic Pain

Other GYN _____

Female Obstetrical History for each of your children: Please provide as much information as possible.

	Birth Date	Weight	Vaginal/Cesarean	Prolonged Pushing?	Tearing/Forceps
1.					
2.					
3.					
4.					

Any other comments or questions that have not been addressed above?

_____

_____

_____

_____

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Pelvic Floor Concerns: Please provide information on any of the following that apply to you

		BLADDER	BOWEL
How many accidents/day:	Small (less than ½ cup)	_____	_____
	Large (greater than ½ cup)	_____	_____
Do you wear protection?		____ Y ____ N	____ Y ____ N
If yes, what type?		_____	_____
Number of changes/day?		_____	_____
How often do you use the toilet during the day?		_____	_____
Do you experience strong urges to urinate or have a BM?		____ Y ____ N	____ Y ____ N
If yes, how much warning time to get to the toilet?		____ Seconds	____ Seconds
		____ Minutes	____ Minutes
Do you ever leak when have a strong urge?		____ Y ____ N	____ Y ____ N
Do you leak with….		_____Coughing	_____Coughing
		_____Laughing	_____Laughing
		_____Sneezing	_____Sneezing
		_____Lifting	_____Lifting
		_____Bending over	_____Bending over
		_____Sexual activity	____Sexual activity
		Other_____	Other _____

How many times do you get up to urinate at night? _____

Do you feel you are able to empty completely?	____ Y ____ N	____ Y ____ N
Do you have pain/burning with voiding?	____ Y ____ N	____ Y ____ N
Do you have any trouble starting your stream?	____ Y ____ N	____ Y ____ N
Do you dribble after urinating?	____ Y ____ N	____ Y ____ N

Do you ever see blood in your urine or in your bowel movements? _____

Does your urine have a noticeable color or odor? Please explain _____

Do you experience abdominal bloating or tenderness? _____

Do you have constipation or diarrhea or both? _____

Other comments or information to be added: _____

_____

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