



**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 I 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.

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
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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



### Clarification of Restore Motion’s Medicare Status

Restore Motion is not a Medicare provider. If Medicare is your primary insurance and you are a Medicare beneficiary, we are not able to provide physical therapy services for you.

Some clients choose to work with our therapists as part of our Wellness Program. The Restore Motion Wellness Program allows clients to enjoy the benefit of working with our physical therapists on an individual basis to improve the quality of their well-being, mobility, and overall function.

Participants in the Wellness Program will receive an invoice for services rendered, “Wellness and Maintenance.” We will not issue an invoice with diagnosis codes or CPT codes for medical reimbursement.

The Restore Motion Wellness Program is designed to encourage optimal health and mobility similar to performance enhancement in the athletic population tailored to your needs, whatever your age.

Frequently Asked Questions:

Q: *Can I submit to my invoice to Medicare to get a denial that I can then submit to my secondary insurance for reimbursement?*

A: No. Restore Motion is not a Medicare provider. Invoices for Wellness and Maintenance submitted will not result in a Medicare denial suitable for submission for secondary insurance reimbursement.

Q: *Why doesn’t Restore Motion participate with Medicare?*

A: By maintaining non-participation status, we can focus on care without the administrative burden of the constant changes in Medicare reimbursement. Restore Motion does not want insurance companies to dictate the type of treatments we use in patient care. We can use diverse and effective techniques to meet the needs of our clients being a non-participating provider.

### MEDICARE ABN

Medicare does not pay for all your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular service does not mean you should not receive it. Right now, in your case, Medicare will not pay for physical therapy treatment for the following reasons checked below.

- ✓ The services provided here will be considered as a management of a maintenance and/or wellness program, not rehabilitative in nature, under Medicare guidelines. Medicare does not consider management of a maintenance and/or wellness program as reasonable and/or necessary.
- ✓ The frequency of the physical therapy visits is less than two to three times per week.
- ✓ The duration of physical therapy services is longer than what Medicare considers reasonable and necessary, which is usually eight weeks.
- ✓ You will not be seeing the referring doctor every 30 days.
- ✓ Your physical therapist is not a participating provider for Medicare, therefore, you **will not** be able to submit claims to Medicare for reimbursement.

**Beneficiary Agreement:** I have been notified by my physical therapist that in my case Medicare will deny payment for the services identified above for the reason stated. I agree to be personally and fully responsible for the payment.

Client Name: \_\_\_\_\_ (please print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Intake Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_
Address: \_\_\_\_\_
Date of Birth \_\_\_\_\_ Email: \_\_\_\_\_
Insurance: \_\_\_\_\_ 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? \_\_\_\_\_

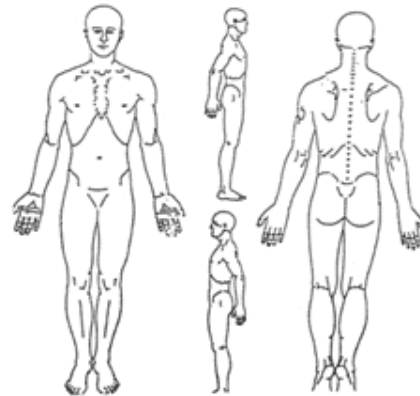
Explain what caused the prior episodes: \_\_\_\_\_

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

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.**

- |   |  |
|---|--|
| <input type="checkbox"/> Rheumatoid Arthritis                           | <input type="checkbox"/> Congenital heart defect             |
| <input type="checkbox"/> Osteoarthritis _____                           | <input type="checkbox"/> Heart problems/heart disease        |
| <input type="checkbox"/> Diabetes Type I or 2                           | <input type="checkbox"/> High or low Blood Pressure          |
| <input type="checkbox"/> Cancer _____                                   | <input type="checkbox"/> Pacemaker                           |
| <input type="checkbox"/> Tuberculosis                                   | <input type="checkbox"/> Chest pain/angina/palpitations      |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Circulation problems or blood clots |
| <input type="checkbox"/> Sexually transmitted diseases or HIV/AIDS      | <input type="checkbox"/> Bronchitis/pneumonia                |
| <input type="checkbox"/> Hepatitis A, B, C                              | <input type="checkbox"/> Emphysema                           |
| <input type="checkbox"/> Osteoporosis or Osteopenia                     | <input type="checkbox"/> Asthma                              |
| <input type="checkbox"/> Currently Pregnant or attempting pregnancy     | <input type="checkbox"/> Bleeding disorders                  |
| <input type="checkbox"/> Thyroid Condition                              | <input type="checkbox"/> Using blood thinners                |
| <input type="checkbox"/> Liver disease                                  | <input type="checkbox"/> Toxoplasmosis                       |
| <input type="checkbox"/> Poor balance or recent falls                   | <input type="checkbox"/> Fibromyalgia                        |
| <input type="checkbox"/> Dizziness/vertigo/fainting/blackouts           | <input type="checkbox"/> Recurrent muscle/ joint pain        |
| <input type="checkbox"/> Severe headaches                               | <input type="checkbox"/> Kidney disease/stones               |
| <input type="checkbox"/> Gastrointestinal issues (IBS, Crohn's)         | <input type="checkbox"/> Prostate problems                   |
| <input type="checkbox"/> Abdominal pain/bloating/gas                    | <input type="checkbox"/> Lyme disease, tick related diseases |
| <input type="checkbox"/> Heartburn/GERD                                 | <input type="checkbox"/> Multiple sclerosis                  |
| <input type="checkbox"/> Gout   | <input type="checkbox"/> Epilepsy/seizure disorders          |
| <input type="checkbox"/> Depression/Anxiety                             | <input type="checkbox"/> Anemia                              |
| <input type="checkbox"/> Psychological _____                            | <input type="checkbox"/> Latex Allergy                       |
| <input type="checkbox"/> Chemical dependency (i.e. alcoholism or drugs) | <input type="checkbox"/> Skin problems _____                 |
| <input type="checkbox"/> Food intolerance _____                         | <input type="checkbox"/> Menopause                           |
| <input type="checkbox"/> Other _____                                    |  |

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Unexplained Fevers          | <input type="checkbox"/> Chest Pain/Tightness                | <input type="checkbox"/> Night Sweat             | <input type="checkbox"/> Trouble Breathing          |
| <input type="checkbox"/> Excessive Fatigue           | <input type="checkbox"/> Persistent Cough                    | <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Nodes (groin/arm/pit/neck) |
| <input type="checkbox"/> Stiffness in Joints         | <input type="checkbox"/> Swollen Ankles/Legs                 | <input type="checkbox"/> Easy Bruising           | <input type="checkbox"/> Difficulty swallowing      |
| <input type="checkbox"/> Black/Bloody Stool          | <input type="checkbox"/> Urinary Incontinence                | <input type="checkbox"/> Painful Urination       | <input type="checkbox"/> Blood in urine             |
| <input type="checkbox"/> Change in appetite          | <input type="checkbox"/> Change in Bowel Habits              | <input type="checkbox"/> Difficulty Sleeping     | <input type="checkbox"/> Joint Swelling/Warmth      |
| <input type="checkbox"/> Change in menstruation      | <input type="checkbox"/> Unusual discharge from vagina/penis | <input type="checkbox"/> Unexplained Weight Loss |   |
| <input type="checkbox"/> Unusual Stress in Work Life | <input type="checkbox"/> 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



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?) \_\_\_\_\_





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

**Males: Prostate/Testicular Problems?**

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**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?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

	<b>BLADDER</b>	<b>BOWEL</b>
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:	_____	
	_____	