MVMT

Physical Therapy, PLLC

PATIENT INTAKE QUESTIONNAIRE

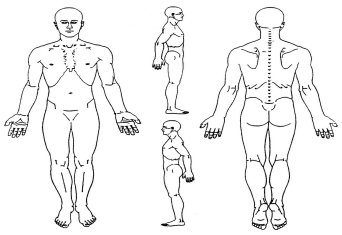
Name	Date
Address	
City	State/Zip
Home #	Cell #
Email	
Occupation	Age/DOB
Height Weight	Date of Onset
Please describe your symptoms	
Have you had similar episodes in the past? ☐ **Y** ☐ **N**	**If Yes**, were you treated? ☐ **Y** ☐ **N**
Did you have, or are you planning surgery? ☐ **Y** ☐ **N**	If **Yes**, date of surgery
Are injuries due to auto or work accident? ☐ **Y** ☐ **N**	**If Yes**, date of accident
Have you stopped working due to your injury? ☐ **Y** ☐ **N**	**If Yes**, date
Please list prior related episodes, orthopedic injuries, and surgeries (with approximate dates)	
Have you had any imaging? ☐ Xray ☐ MRI ☐ CT	Date Result

Describe your pain

☐ Sharp
☐ Dull/achy
☐ Throbbing
☐ Numbness/Tingling
☐ Shooting
☐ Other:

☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (0-25%)
☐ Worse AM
☐ Worse PM

Mark an X over your areas of pain



Circle the intensity of your pain at its **WORST**

0	1	2	3	4	5	6	7	8	9	10
No pain	Slight		Mild		Moderate		Severe		Worst Possible	

How do the following activities affect your pain?

	Standing	Walking	Lifting	Pushing/ Pulling	Typing/ Writing	Stairs	Bending Forward	Bending Backward	Reaching
Better									
Worse									
No change									

	Squatting	Kneeling	Sitting	Driving	Other
Better					
Worse					
No change					

Please indicate any additional medical conditions

	Y	N		Y	N
Unexplained Weight Loss/Gain >10 lbs	☐	☐	Stroke	☐	☐
Unexplained Nausea or Vomiting	☐	☐	Pacemaker	☐	☐
Unexplained Fatigue	☐	☐	Neurologic Disorder	☐	☐
Dizziness/Vertigo	☐	☐	Psychiatric Treatment	☐	☐
Difficulty Breathing	☐	☐	Hernia	☐	☐
Incontinence ☐ bowel ☐ bladder	☐	☐	Cancer	☐	☐
Night Sweats	☐	☐	Infectious Disease	☐	☐
Night Pain	☐	☐	Rheumatoid Arthritis	☐	☐
Headaches	☐	☐	☐ Osteoporosis ☐ Osteopenia	☐	☐
Fainting Spells	☐	☐	Osteoarthritis	☐	☐
Pain not relieved by change in position	☐	☐	Multiple Sclerosis	☐	☐
Falls	☐	☐	Metal Implant	☐	☐
Seizures	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Allergies to heat, ice, latex, adhesives, meds?	☐	☐
High Blood Pressure	☐	☐	Women: Are you pregnant?	☐	☐
Heart, Kidney or Thyroid	☐	☐			

If Yes to any of the above, please give appropriate details. Please list any condition not listed above:

Please list all medications you are currently taking

Medication	Dose	Freq	Method

I hereby attest, to the best of my knowledge, that the above is correct and accurate.

Signature	Date

PATIENT AGREEMENT - Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible, we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing the bottom.

Please Initial All Boxes

☐ **Late cancellations:** If you wish to change or cancel an appointment, we require a minimum of 24 hours advanced notice. Anything less will result in a $50 fee. This allows someone else to reserve a spot on the schedule so please be courteous and responsible. Should you reschedule another appointment in the same M-F week, the fee will be waived.

☐ **No-shows:** If you fail to show up for a scheduled appointment without notice, a $50 fee will be charged. Should you fail to show up for 3 appointments, all future appointments will be cancelled.

☐ **Payments or copayments** are due at each treatment session.

☐ **Cell phones** must be silenced. While we realize emergencies may arise, please be respectful by placing your phone on vibrate.

☐ There is **no daycare** for babies or children. Patients are encouraged to arrange for child care prior to their physical therapy session.

☐ As a courtesy to you, we will submit all your insurance claims and the necessary documentation in a timely manner. If your insurance company fails to pay or doesn't meet our minimum reimbursement, you will be responsible for the balance.

☐ **Financial hardship:** If you are experiencing financial difficulties and are unable to afford the cost of our services, we have a "Financial Hardship Form" which may be filled out. If you qualify for financial assistance according to the federal guidelines, we will waive or discount your portions of the bill.

We look forward to helping you!

Print Name

Signature | Date

PATIENT RESPONSIBILITY

- I understand that payment for services is due before each treatment session.
- I understand and acknowledge that submission of claims is not a guarantee of payment. If for any reason my carrier does not cover any and/or all of my physical therapy treatments, I agree that I am responsible for the payment of the entire amount.
- New York State law mandates a physician's prescription for physical therapy treatments. Unless otherwise specified, each is valid for only four (4) weeks from the date listed on the prescription.
- I understand that it is my responsibility to obtain a new prescription at the end of the specified time period. If I fail to obtain an updated prescription, I understand that I will be responsible for payment of services not covered by my carrier.
- I understand that it is my responsibility to notify MVMT Physical Therapy of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization.
- I understand and agree that if I claim Worker's Compensation or Auto No-Fault benefits and am subsequently denied, I will be financially responsible for the services rendered.

I hereby authorize MVMT Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Name	
Responsible Party Signature	
Relationship to Patient	Date

Name on Card	CC Type ☐ Visa ☐ MC ☐ Discover
CC#	Exp

I hereby authorize MVMT Physical Therapy to charge the credit card on file for services rendered.

Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

PURPOSE: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW TO YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE GOES INTO EFFECT ON APRIL 14, 2003 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We nee the record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways that we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

a. Law Requires Us To:

i. Keep medical information private.
ii. Give you this notice describing our legal duties, privacy practices and your rights regarding medical information.
iii. Follow the terms of this notice that is now in effect.

b. We Have The Right To:

i. Change the privacy practices and terms of this notice at any time, provided that the law permits the changes.
ii. Make the changes in our policy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes were made.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes the different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all the ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purposes not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us and confirming receipt of written authorization.

a. For Treatment: The HIPAA regulation permits nearly unlimited sharing of information among providers who are involved in a patient's treatment. Uses and disclosures of information commonly include collection of information from the patient by a physician or other medical practitioner for performing diagnostic tests and reviewing results, consulting with other providers on diagnosis or treatment, referring a patient to another provider, and transmitting information to another provider such as phoning prescriptions into a pharmacy or placing an order for an ice machine, brace, or other durable medical equipment.

b. For Payment: We are permitted to disclose to the patient's health plan, any information needed to process a claim. For example: to determine whether a patient is eligible for coverage under a health plan, to determine whether tests or services are covered under a health plan, to submit a claim or inquire about the status of a claim, to process payment or claims remittances, and to process credit card transactions.

c. For Health Care Operations: Staff may use and disclose only the "minimum necessary" information for the task at hand. This includes: maintenance of medical records, maintenance of accounting records, quality assurance activities, staff performance evaluations, conducting financial and management audits, investigating complaints, supporting legal activities, resolving grievances, and general business management.

d. For Law Enforcement: Your health information may be disclosed to law enforcement agencies to facilitate investigations, inspections, or mandated reporting. Your health information may be disclosed to public health agencies as required by law.

4. HIPAA NOTICE OF PRIVACY PRACTICES

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

5. INDIVIDUAL RIGHTS

You have the right to request restrictions on the use and disclosure of your protected health information, the right to receive confidential communications regarding your treatment and condition, the right to inspect and copy your health information, the right to amend or submit corrections to your health information, and the right to receive a printed copy of this notice. As permitted by federal regulations, we require that a request to copy or review protected information be submitted in writing. If you would like to submit a comment about our privacy practices, you may do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to: HIPAA Privacy Official, MVMT Physical Therapy.

6. ACKNOWLEDGEMENT OF FORM

I have received the Notice of Privacy Practices and I have been provided the opportunity to review the contents.

Name (please print clearly): _____

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize medical providers and personnel of MVMT Physical Therapy to discuss and/or release my protected health information with:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall be in effect as of the date above and will expire 365 days from date of signing.

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal or State law.
- I understand that I have the right to refuse to sign this authorization.

Print Name	
Signature	Date