In Motion Therapy

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

PATIENT INFORMATION

First Name: _____ **MI:** ____ **Last Name:** _____

Preferred Name: _____ **Male ( ) Female ( )**

DOB: _____ **SSN:** _____ **Marital Status:** _____

Mailing Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

EMAIL: _____

Preferred Appointment Reminder: (CHOOSE ONE) HOME PHONE / CELL - TEXT ___CALL ___

Primary Care Physician: _____ **Phone Number:** _____

How did you hear about us? _____

Is This Visit Related to A Workers Compensation Claim? YES: _____ **NO:** _____

Employer Name: _____ **Employer Phone Number:** _____

Is This Visit Related to An Auto Accident? YES: _____ **NO:** _____

Responsible Party Information (If Other than Patient)

First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: _____ **Relationship to Patient:** _____

Signature of Responsible Party: _____ **Date:** _____

Signature of Patient: _____ **Date:** _____

In Motion Therapy

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

Name: _____ **Date:** _____

What body part are you being seen for today? _____ Circle one: Right Left Both

When and ***how*** did your problem start? (If specific date is unknown, please estimate time of year)

_____

Did you have surgery for this problem? _____ Date of Surgery: _____

Pertaining to this problem you are being seen for today, have you had any:

X-Ray Date:_____ Location:_____ **MRI** Date:_____ Location:_____

CT Date:_____ Location:_____ **EMG** Date:_____ Location:_____

Other:_____

Please rate your pain on a scale of **0** (no pain) to **10** (unbearable):

At Worst_____/10 Current_____/10 At Best _____/10

Describe your pain (please circle ***one*** that most applies):

burning sharp dull/ achy throbbing shooting numbness/tingling

constant intermittent worse in morning worse in evening

What makes your pain worse? _____

What makes your pain better? _____

Are any of your daily activities affected? If so, how? _____

What are your **goals** for therapy? _____

MEDICAL HISTORY Please circle all that applies to you:

Alzheimer's	Cancer Type: Year:	Traumatic brain injury Type: Year:	Fracture/Expected Fracture
Cardiovascular Disease Type: Year:	Huntington's Disease	Immunosuppression	Unexplained Weight Loss
Stroke/TIA Type: Year:	Lupus	Blood Clots	Parkinson's Disease
Current Infection Type:	Multiple Sclerosis	Dizziness	Obesity
Diabetes Type:	Muscular Dystrophy	Falls	Pacemaker
Fibromyalgia	Rheumatoid Arthritis	Headaches	Osteoporosis
High Blood Pressure	Osteoarthritis	Mental Health Illness Type:	Do You Smoke:

Please list or attach current medications and/or supplements: _____

_____

Do you have any allergies? _____

Have you had any physical or occupational therapy this year? _____

Are you receiving or have you received home health care of any kind this year? _____

DO YOU HAVE A PACEMAKER? _____

I hereby consent to the evaluation and treatment of my condition by a licensed therapy provider employed by In Motion Therapy.

Patient Signature: _____ Date: _____

In Motion Therapy

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

HIPAA Release of Information

Due to privacy laws, if you would like us to talk to anyone other than yourself regarding your appointments, billing, or other medical information, you will need to list them below. (i.e., spouse, children, parents, friend, neighbor etc.) **This is not for release to another physician**.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Emergency Contact if different from above:

Name: _____ Relationship: _____ Phone: _____

I acknowledge being given access to this practice's HIPAA Privacy Policies, which are located in the waiting area.

The undersigned certifies that he/she is the patient or the duly authorized representative of the patient and agrees to these terms.

Print Name: _____

Signature: _____ **Date:** _____

In Motion Therapy

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

Payment Consent

I hereby authorize payment of medical benefits billed to my insurance by In Motion Therapy. I acknowledge that if I do not provide my current insurance/work comp or auto Information at time of 1st appointment, I will be responsible for the charges incurred.

Please present all insurance cards to be scanned.

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. (Dry Needling, Supplies) I agree to pay all copayments, coinsurance, and deductibles at the time of services. I understand that any unpaid balances will be my responsibility.

If my insurance requires a referral or authorization in order to be seen, I will obtain it before my visit.

All payments for "self-pay" patients will be due at the **time of service**.

Patient Signature_____ **Date**_____

In Motion Therapy

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8699

Appointment Cancellation / No Show Policy

At In Motion Therapy, we believe that each patient is entitled to their therapist's full attention during their appointments. To help achieve this, our office offers the option of voice call or text reminders the day before each appointment to remind of appointment time.

If you wish to cancel your appointment, we ask that this be done 24 hours in advance. If you cannot do so during normal office hours, (8-6 Monday through Thursday, 8-5 Friday), then please call and leave a message on our voicemail.

A short notice cancellation restricts our ability to fill that space with another patient needing our services. **If any new patient or preexisting patient fails to appear or cancel an appointment without 24-hour notification, a $50.00 fee will be applied to your next billing statement**. With reasonable consideration of circumstances, (unforeseen emergencies, sickness or weather-related delays), we will handle each instance on a case-by-case basis. The above charge is not covered by any insurance plan; therefore, you will be personally responsible for this fee before any further appointments can be scheduled.

Attention Workers' Compensation Patients: All cancellations/no shows are required to be reported to your WC adjusters.

Patient/Guardian Signature Date