LIFEMOTION Physical Therapy

PATIENT NAME: ______________________ PHONE # ____-____-____

STREET ADDRESS: ______________________

CITY: ______________________ STATE: ________ ZIP: ________

DATE OF BIRTH: ____/____/____ SEX: ______ AGE: ______ MEDICARE # ______________

CURRENTLY EMPLOYED: YES / NO MARITAL STATUS: S M D W

EMPLOYER NAME: ______________________ PHONE: ____-____-____

EMPLOYER ADDRESS: ______________________

Who may we thank for this referral: ______________________

NEXT OF KIN: ______________________ RELATIONSHIP: ______________

CONTACT PHONE: ____-____-____ ADDRESS: ______________________

PRIMARY INSURANCE: ______________________ POLICY #: ______________

POLICY HOLDER NAME: ______________________ INS CARDS COPIED: YES / NO

SECONDARY INSURANCE: ______________________ POLICY #: ______________

POLICY HOLDER NAME: ______________________ IF SPOUSE? D.O.B: ____/____/____

I authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and / or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure. I attest that all of the above is true and correct to the best of my knowledge.

______________________ ____/____/____

Patient, Parent or Guardian Signature **Today's Date**

TO BE COMPLETED BY OFFICE:

NAME OF REFFERRING DOCTOR: ______________________ PHONE: ____-____ ____

NEW REFERRING DOCTOR NPI #: ______________________ START OF CARE DATE: ____/____/____

DIAGNOSIS: ______________________ ONSET OR INJURY DATE: ____/____/____

Medical History Information

Name: ______________________________

Height: __________ Weight: __________

YES NO Are you under the care of a physician? If yes, please state name, address, and phone number of physician:

____

____

YES NO Have you had any serious illnesses, operations, or been hospitalized in the past 5 years? If yes, please explain:

____

____

YES NO Are you taking medicine, including non-prescription medication? If yes, what medications (including dosage and frequency)?

____

____

YES NO Do you have any disease or problem not listed below that you feel we should know about? If yes, please explain:

____

____

Approximately when was your last physical exam? ______________________________

Do you have any, or have you had any of the following diseases or problems?

Yes	No	Diabetes	Yes	No	Hypertension
Yes	No	Alcoholism	Yes	No	Pace-Maker
Yes	No	Allergies	Yes	No	Immune System
Yes	No	Anemia	Yes	No	Liver Disease
Yes	No	Bowel	Yes	No	Mental Illness
Yes	No	Cancer	Yes	No	Renal Disease
Yes	No	Circulatory	Yes	No	Respiratory
Yes	No	Nervousness	Yes	No	Seizures
Yes	No	Depression	Yes	No	Loss of spouse
Yes	No	Easily Frustrated	Yes	No	Stroke
Yes	No	Drug Abuse	Yes	No	Loss of socializing skills
Yes	No	GI disturbances	Yes	No	Urinary
Yes	No	Hearing Problems	Yes	No	Visual
Yes	No	Heart Disease			

I certify that I have read and understand the above. I acknowledge that my questions if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the program or any of its staff responsible for any errors or omissions that I may have made in the completion of this form

Patient's Signature (or representative completing form) ______________________________ Date: ____/____/____

Indigence Status Attachment
Confidential Patient Information

The following information is required to process the request for Indigence Status. Please answer all questions below and give the additional comments if necessary.

Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment by Federal Law.

1. Are you currently eligible or presently enrolled in the Medicaid program? Yes No

Date Eligible / Enrolled _______/_______/_______ Medicaid #: ______________________________

2. Does anyone other than yourself have control or responsibility for your finances or debts incurred by you?

Yes No If Yes, please list the Name, Address, & Phone of that responsible party:

IF YOU ANSWER NO TO THE HIGHLIGHTED QUESTIONS, JUST SIGN THE BOTTOM.

____

____

____

3. Please list dollar value of total assets in your name which could be converted to a cash value and are not necessary for daily living. $ ______________

4. Please list your total monthly income received from all sources. $ ______________

5. Please list your approximate total monthly expenses. $ ______________

6. Please list approximate amount of your total liabilities. $ ______________

7. Are you presently covered under any insurance, supplemental or primary (other than Medicaid) for which you may receive benefits?

Yes No If Yes, please list Name and Member I.D. number:

____

Additional comments: ____

____

____

Patient's Signature: ______________________ Printed Name: ______________________

Today's Date: _______/_______/_______ Witness: ______________________

Insurance Authorization – Release Form

Patient's Name:____

Patient's Medicare #: ________________________________

Instructions: Please read this form carefully, check applicable spaces and sign.

Insurance Authorization – Patient Release and Authorization:

__X__ I hereby authorize payment directly to LIFEMOTION Physical Therapy for the benefits due to me in my pending claim and / or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and / or the facilities regular charges for therapy this treatment period.

____ I further authorize the release of any medical information required by my insurance carrier (s).

____ I understand that I am financially responsible for charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

Medicare Authorization – Patient Release and Authorization:

____ I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

____ I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers of any other information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment by Federal Law.

Insurance Acknowledgement – Rehabilitation Services Billing and Reimbursement:

____ I am aware that Medicare and / or insurance may not reimburse some costs of my rehabilitation.

____ I am aware that I will be billed for these non-reimbursed services.

____ I have read the above and understand that I am financially responsible for paying any and all charges incurred in the Rehabilitation Program not reimbursed.

____ However, at this time I am financially unable to pay the balance of the charges for which I am responsible. Please accept this form as a request for Indigence Status which will excuse me from further payment of the remaining balance due for said charges upon approval from LIFEMOTION Physical Therapy If applying for Indigence Status of the Indigence Information Attachment form must be completed.

Signature of Patient: __________________________ Printed Name: ____________________________

Today's Date: ______/______/______ Witness: ________________________________

Primary Payer Questionnaire

The questions below are for beneficiaries age 65 or older, and are used to comply with Medicare Regulation #42 CFR 489.20 (F)

1. Are you currently working full or part time? Yes No

2. If married, is your spouse working full or part time? Yes No

3. Are you currently under any employer group health plan? Yes No
If yes, please provide the following information:
Name of insured ______________________
Relationship to Patient ______________________
Name of employer ______________________
Name of Ins. Carrier ______________________
Group / Policy # ______________________

4. Are you entitled to Black Lung benefits? Yes No

5. Is this service for treatment of a work related injury? Yes No
If yes, please provide the following information:
Name of insurer ______________________
Name of policy holder ______________________
Date of injury _____/_____/_____
Claim number ______________________

6. Is this service for treatment of an auto related injury?
If yes, please provide the following information:
Name of insurer ______________________
Name of policy holder ______________________
Date of injury _____/_____/_____

7. Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

Signature of Patient ______________________ Date _____/_____/_____

Printed Name of Patient ______________________ Witness: ______________________

Records Release / Authorization

To: ____

____

____

I hereby authorize and request you to release to:

LIFEMOTION PHYSICAL THERAPY

A brief history in your possession concerning my illness and /or treatment.

Name: ____

Address: ____

City/ State/ Zip: ___________________________________

Signature: ______________________________ Date: ____/____/____

Witness: ____________________

LIFEMOTION
PHYSICAL THERAPY
"Movement is Life"

INFECTIOUS DISEASE SCREENING

1. Have you traveled outside of the U.S in the past 21 days?

   ___YES ___NO

   If yes, where______________________________

2. Has a close contact (Household Member) traveled outside of the U.S in the past 21 days?

   ___YES ___NO

   If yes, where______________________________

3. Do you have a fever (Temp of more than 100.4F) or feel hot?

   ___YES ___NO

4. Do you have a cough, shortness of breath or sore throat?

   ___YES ___NO

5. Are you vomiting or having diarrhea?

   ___YES ___NO

Patient Name:____________________ Date________________

Temperature______________________________

LIFEMOTION PHYSICAL THERAPY

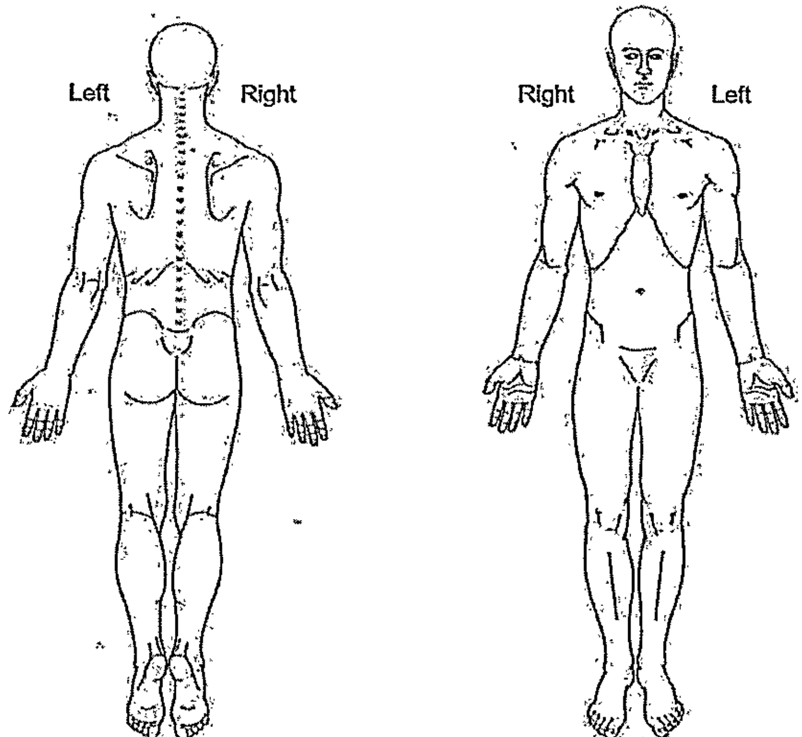
NAME: ____________________

NEW PATIENT PREASSESSMENT QUESTIONNAIRE

PAIN QUESTIONNAIRE

We would appreciate you taking some time to answer this questionnaire. It asks about your pain, and how your pain affects your life. These details will help us to better understand your needs and therefore we encourage you to fill it in as fully as possible.

1. Where is Your Pain?
On the diagram below please shade the areas where you experience pain.



2. How long have you had your pain?

____________________ (Years) ____________________ (Months)

3. How severe is your pain?
If zero (0) means "no pain" and ten (10) means "the worst pain you can imagine", what have been your levels of pain over the last week?

	No pain									Worst pain you can imagine
Lowest pain	0	1	2	3	4	5	6	7	8	9	10
Highest pain	0	1	2	3	4	5	6	7	8	9	10
Usual pain	0	1	2	3	4	5	6	7	8	9	10