Motion Dynamics Physical Therapy Patient Information Form

Thank you for choosing Motion Dynamics Physical Therapy. In order to serve you properly, we will need the following information. All information will be strictly confidential. Please print clearly.

Date:_____ How did you hear about us?_____

Patient Name:_____
Last First M

Address:_____City:_____Zip:_____

DOB:_____ Age:_____ Sex:_____ SS#:_____ Martial Status:_____

Phone:_____ Cell Phone:_____ Work Phone:_____

Type of Injury: Employment_____ Auto_____ Other_____

Are you represented by an Attorney? Yes_____ No_____

Referring Physician:_____

Emergency Contact:_____ Phone:_____

Patients Employer:_____ Phone:_____

Insurance Information:

Primary Insurance_____ Policy #:_____

Relationship to insured:_____ Group #:_____

Mailing Address:_____

Secondary Insurance:_____

Workers Comp Information:

Comp Carrier:_____ Phone:_____

Address:_____

Adjuster:_____ Verified By:_____

Attorney Information:

Name:_____ Phone:_____

Address:_____

PAST MEDICAL HISTORY FORM

Patient ~~Name~~ signature: _____ Date: _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other: _____
☐ Cause unknown ☐ Athletic / recreational injury

Have you had a related surgery? ☐ Yes ☐ No

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

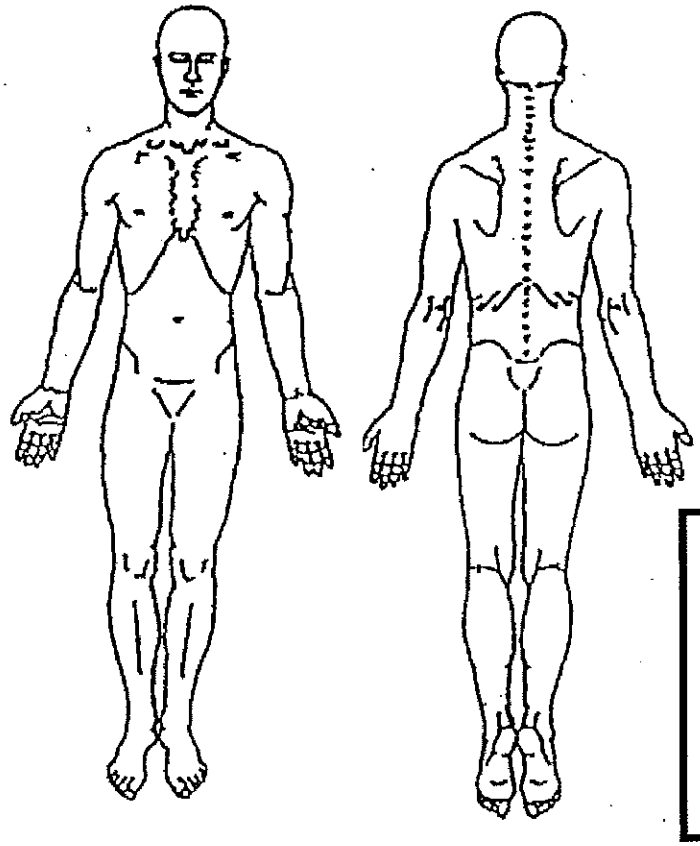
	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Stroke/CVA	☐	☐	Other: _____		

If yes on any of the above, please briefly explain and give approximated date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition:

Please indicate below where your symptoms are located.



KEY:

Numbness	**========**
Pins & Needles	**ooooooo**
Burning Pain	**xxxxxxxx**
Stabbing Pain	**/ / / / / / / /**

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

_____ _____ _____ _____

Patient's Signature Date Signature of Guardian if patient is a minor Date

_____ ____/____/____

Therapist Signature Date

Motion Dynamics Physical Therapy

Consent for Treatment: I as a patient consent to physical therapy treatment at Motion Dynamics Physical Therapy as prescribed by my physician. I consent to maintain the confidentiality of other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than myself.

Patient Signature:_____Date:_____

Authorized Release of Information: I hereby authorize Motion Dynamics Physical Therapy to release medical records pertaining to my treatment of any entity that is responsible for payment of physical therapy charges. I understand that this authorizes my insurance company to pay any benefits directly to Motion Dynamics. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or copayments. In addition, I authorize Motion Dynamics to request medical records from other entities on my behalf.

Patient Signature:_____Date:_____

HIPPA Patient Information Consent: I have read and fully understand Motion Dynamics Notice of Information Practices. I understand that Motion Dynamics Physical Therapy may use or disclose any personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations elated to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Motion Dynamics will consider requests for restriction on a case by case basis but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Motion Dynamics Physical Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Signature:_____Date:_____

Motion Dynamics Physical Therapy Patient Responsibility Guidelines

On behalf of Motion Dynamics we would like to thank you for choosing our clinic. As a provider of Physical Therapy, we are an extension of your physician. In order to achieve the best results it is very important that your treatment program follow the request of your physician. In addition, your end results rely heavily upon your physical therapist's recommendations and your compliance with your treatment program. Below please find a list of Motion Dynamic's policies:

- Appointments will be scheduled at your convenience
- Our office hours are as follows:
  Monday – Friday 9:00am – 5:00pm
- Visits will follow M.D. referrals. Your physician has ordered physical therapy ____ times per week for ____ weeks.
- Patients are expected to be on time. Please contact our office if you will be late or need to reschedule. If you are 15 minutes or more late, it is possible that your appointment will have to be rescheduled. If you need to reschedule an appointment, please call our office and arrange for a make-up appointment. The make-up appointment should be in the same week; preferably the next day.
- If there is a problem with consistent missed appointments, we reserve the right to charge $15 if we are not given adequate cancellation notice. This fee will not be billed to your insurance company. If must be paid by the patient on the following visit.
- Please dress appropriately but comfortably, as many treatments include exercise.
- Office phone – 504-277-6052
  504-277-6053 Fax

_____ _____

Patient Signature Date

Patient:_____ Date:_____

Please give a brief description of your accident/injury

_____

_____

_____

_____

_____

_____

_____

_____

_____

HIPPA Patient Information
Motion Dynamics Physical Therapy
Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Motion Dynamic's Legal Duty
Motion Dynamics is required by law to protect the privacy of your personal health information provide this notice about our information practices and follow the information practices described herein.

Uses and disclosures of Health Information
Motion Dynamics uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, o information about treatment alternatives or other related benefits that could be of interest to you.

Motion Dynamics may also use or disclose your health information without prior authorization for public health purposes, auditing purposes and emergencies. It may also be used by law for the following Judicial Administrative Release; Health Oversight Release, Research; Law Enforcement Public Health Activities; Coroner's/Medical Examiners Request for identification of deceased and specialized Government Functions.

In any other situation Motion Dynamic's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Motion Dynamics may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on you next visit. You may also request an updated copy of our notice at any time.

Patient's Individual Rights
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct ay inaccurate or incomplete information in you records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purpose.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you when required by law or I emergency circumstances. Motion Dynamics will consider all such request on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints
If you are concerned that Motion Dynamics may have violated your privacy rights o if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address below. You may also send a written complaint to the US Department of Health ad Hunan Services. For further information on Motion Dynamic's health information practices, or if you have a complaint please contact the following person:

Kathy Noland
Motion Dynamics