MOTIONSTABILITY
PHYSICAL THERAPY

patient profile

Date
How Were You Referred?

Last Name
First Name
Middle

Date of Birth
Age
Gender (Male or Female)

Social Security Number

Address

City/State
Zip Code

Phone (Home)
Phone (Mobile)

Phone (Work)
Fax

Email *Note: your email address will be added to our e-Newsletter database to receive updates on our practice, please inform us if you would not like to be added.*

If patient is a minor, name of parent/guardian

Parent/guardian Phone Number

Emergency Contact Name
Emergency Contact Phone

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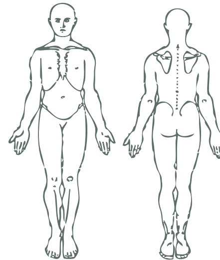
physical therapy patient history

Name

What is your chief complaint?
Please use the picture to the right to indicate the affected areas:



When did the problem begin?

How has the problem affected your daily life? (e.g. Work/Recreation)

Have you had previous similar occurrences of these symptoms?

If yes, how often per year?

Special tests performed (Xray, MRI, etc) and findings

Past medical history with dates (accidents, injuries, medical, surgeries, etc)

Current Medications

What are your goals and expectations of Physical Therapy?

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condition & consent for outpatient treatment

1. COOPERATION WITH TREATMENT:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss this with my physical therapist.

2. NO WARRANTY:

The physical therapy department does not promise a cure for my condition. They will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

3. INFORMED CONSENT TO TREATMENT:

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The department provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

Potential Risks:

You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is temporary and will probably subside in 24 to 48 hours.

Potential Benefits:

These include an improvement in your symptoms, an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain. You will have greater knowledge on managing your condition and the resources available to you.

Alternatives:

All physical therapy treatment options available for your condition will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

______________________________ ____________

Patient's Signature Date

HEALTH INSURANCE INFORMATION:

Motion Stability Physical Therapy provides quality and individualized physical therapy services based on 55 minute treatment sessions. In order to do so, **Motion Stability is an out-of-network provider.**

As a courtesy, we will verify your insurance benefits before your first evaluation, keeping in mind that it is still the patient's responsibility to confirm and know their own policy benefits. We will also provide services by submitting the patient's claims to their insurance company.

Once the patient's deductible is satisfied they will be responsible to pay an estimated co-insurance amount at the time of the visit. **The insurance company will be billed for our services, with the patient responsible for any uncovered amounts.**

Please contact us for further questions regarding our insurance policies.

SELF PAY (no insurance):

Initial Evaluation: **$160.00 (per 55 minutes)**
Includes complete evaluation, diagnosis and treatment

Follow-up Treatments: **$150.00 (per 55 minutes)**
An itemized bill will be provided after each session.

CANCELLATION POLICY:

A scheduled appointment must be cancelled at least 24 hours in advance or the patient will be charged $150.00 for that appointment by providing the below credit card information.

Please let us know if you have any questions regarding the above information.

Credit Card Number

Expiration Date 3-4 Digit Security Number

Name on Card (Print)

☐ **I agree to treatment on the above terms.**

Signature Date

patient information acknowledgement

I have read and fully understand Motion Stability, LLC Physical Therapy's Notice of Information Practices. I understand that Motion Stability, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related 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 Stability, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Motion Stability, LLC 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 Name (Print) Date

Signature

Parent/Guardian Signature (if patient is a minor)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. We have a legal responsibility to focus on the privacy and security of your Protected Healthcare Information (PHI). The federally mandated program, Health Insurance Portability & Accountability Act of 1996 (HIPAA), has set standards for the disclosure and protection of individually identifiable health information and any medical records related to those individuals. This Act gives you the right of understanding and controlling how your health information is being disclosed. In compliance with HIPAA, we are notifying you of our responsibilities and how we are required to maintain privacy of your records.

There are many different purposes of disclosing your personal information. Some disclosures require written authorization or consent others are covered under the rights of HIPAA, after having made good faith efforts to obtain your acknowledgment of receipt of this notice. We may use or disclose your PHI for the following purposes: treatment, payment, and healthcare operations.

- For Treatment: Sharing your PHI to provide, coordinate, or manage healthcare and related services with those healthcare providers that are involved in your care. For example, sharing information with your referring doctor regarding a follow-up appointment.
- For Payment: Sharing your PHI to obtain reimbursement for services provided to you, confirming coverage with your insurance, billing and collection. For example, sending a bill to your insurance for payment of your visit.
- For Health Care Operations: Sharing your PHI to operate our practice, including but not limited to, evaluating and assessing the quality of our services and health care professionals, or conducting improvement activities. We may also share your PHI for insurance related activities, legal services, and auditors to insure our compliance with the laws set before us. For example, an internal quality assessment review.

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patient information acknowledgement

We are permitted to use or disclose your health information without further authorization from you for the following reasons:

- Required by law
- Required by public health purposes
- To report abuse or neglect
- Required by a health oversight agency for activities authorized by law to monitor the health care system, government programs and compliance with civil rights.
- For judicial and administrative proceedings when required by law
- For law enforcement purposes when required by law to do so
- Required by coroner, medical examiner, or funeral director
- Permitted by law for research purposes
- To prevent or lessen a serious or imminent threat to the health or safety of a person or the public
- Requested by military authorities if you are a member of the armed forces
- To comply with the laws relating to Workers' Compensation or other similar programs

We may contact you by mail or phone to remind you of appointments or to provide information about events at Motion Stability, LLC. Unless you instruct otherwise, we may leave a message for you on an answering device or with any person who answers the phone at your residence.

Other uses and disclosures will be made only with your written consent and authorization. Should you wish to revoke the authorization at any time, you may do so in writing and the sharing of your PHI will be stopped immediately.

Upon a written request from you, the patient, you are granted the following list of rights regarding your protected health information:

- The right to request limits regarding the disclosure of your PHI, specifically related to the sharing with family members, close friends, or any other person identified by you. We will carefully consider your request but are not legally required to agree to it. If agreed upon, we will abide by the limits you have requested. Restriction requests do not apply to the uses that we are legally required or allowed to make.
- The right to request how PHI is communicated to you by our practice. We will agree to your request if it can be provided in an efficient manner.
- The right to inspect and copy your protected health information. Copies of PHI will be charged to you.
- The right to request a correction or update your PHI. If you should request a change of your PHI, you must do so in writing including a reason for the change being made. We will consider the reason for an amendment, but we are not required to agree to a change.
- The right to request and receive a list of disclosures of any PHI made by our office.
- The right to request and receive a paper copy of this notice at any time.

We are required by law to keep this notice updated to reflect any change regarding the manner that PHI is disclosed. You may request a revised copy of this notice should it change at any time.

To File a Complaint: If at any time your privacy rights have been violated or you have a complaint about our practice, you may file a written complaint to: Motion Stability, LLC, PO Box 29524, Atlanta, GA 30359. Your complaint or concerns will not alter or affect the quality of care provided to you by Motion Stability, LLC.

Join ***the movement*** and discover the latest evidence-based practices for reducing recurrent pain. Visit motionstability.com to sign up for our newsletter today.