MOVE

PHYSICAL THERAPY & WELLNESS

803 Harkrider Street, Suite 6, Conway, AR 72032
Phone: 501.358.6170 / Fax: 501.358.6190

Date: _____/_____/_____

**PATIENT INFORMATION**

First Name:_____ Last Name:_____ Initial:_____ Age:_____

DOB:_____Email Address:_____

Mailing Address:_____City:_____State:____Zip:_____

Work Phone:_____ Cell Phone:_____

Employer Name:_____Phone:_____

Address:_____City:_____State:____Zip:_____

Emergency Contact:_____ Phone number:_____

Responsible Party (If patient is a minor):_____DOB: _____

**CARE PROVIDER INFORMATION**

Primary Physician:_____ Phone number:_____

Physician that referred you:_____ Phone number:_____

**WHAT ARE YOU BEING SEEN FOR TODAY?**_____

Onset date of illness/injury: _____ Due to (circle): Work/School/Auto accident/Other _____

If auto accident, what state did the accident occur?_____

**INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)**

Primary Insurance Name:_____

Subscribers Name (If different):_____DOB:_____

ID#:_____Group/Policy #:_____

Patient's Relationship to Subscriber: Self____Spouse____Child_____Other_____

Secondary Insurance Name:_____

Subscribers Name (If different):_____DOB:_____

ID#:_____Group/Policy #:_____

Patient's Relationship to Subscriber: Self____Spouse____Child_____Other_____

**AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**

Claim #:_____Accident Date:_____ Cause:_____

Adjustor/Claim Manager:_____Phone:_____

**ATTORNEY INFORMATION (If applicable)**

Name:_____Phone:_____

Address:_____City:_____Zip:_____

**OUTPATIENT SERVICES CONSENT FOR TREATMENT (PLEASE INITIAL BELOW)**

_____**Consent for Treatment:** I authorize the staff at MOVE Physical Therapy and Wellness to undertake such treatment and procedures as deemed appropriate to improve my condition. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome and completion of my treatment program may be affected.

_____**Personal Property:** I understand that MOVE Physical Therapy and Wellness shall not be liable for loss or damage to any personal items brought to MOVE Physical Therapy and Wellness during my course of treatment.

_____**Release of Information:** MOVE Physical Therapy and Wellness may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. MOVE Physical Therapy and Wellness may disclose all or part of my record to other health care providers including but not limited to hospitals and physicians involved with my care.

_____**Financial Consent:** I understand that I will be financially responsible for any charges not covered by my insurance company. Many insurance policies require some patient responsibility in the form of a copay, deductible, coinsurance, or some combination thereof. I understand copays are due at the time of each appointment, and that I will be billed for any portion of charges my insurance assigns as patient responsibility as claims are processed. I understand that I am financially responsible for the balance.

_____**Assignment of Insurance Billing:** I authorize my insurance benefits be paid directly to MOVE Physical Therapy and Wellness.

_____ _____

**PATIENT / GUARDIAN SIGNATURE** **DATE**

**PATIENT HEALTH QUESTIONNAIRE**

Name:_____Age:_____Date:____/_____/_____

Describe your current complaint or limitation: _____

How did your problem begin?_____

How long ago did your condition begin?_____

List any tests or other interventions for this condition that you have had (e.g….x-rays, MRI, surgery, etc):_____

If you had surgery, please provide date & type of surgery: _____

List the daily activities that you cannot perform: _____

_____

Indicate your level of functioning prior to the onset of this condition: _____

_____

List any environmental or living conditions that you have difficulty with: _____

Has your work status changed because of this condition? ____No____ Yes

If you have ever had a condition listed below in the past, please check the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column.

| PAST | PRESENT | | PAST | PRESENT | |
|---|---|---|---|---|---|
| ____ | ____ | High Blood Pressure | ____ | ____ | Hepatitis |
| ____ | ____ | Angina | ____ | ____ | Epilepsy |
| ____ | ____ | Heart attack | ____ | ____ | Diabetes |
| ____ | ____ | Stroke | ____ | ____ | Arthritis |
| ____ | ____ | Asthma | ____ | ____ | Pregnancy |
| ____ | ____ | HIV/AIDS | ____ | ____ | Incontinence |
| ____ | ____ | Systemic Lupus | ____ | ____ | Pacemaker |
| ____ | ____ | Rheumatoid Arthritis | | | |
| ____ | ____ | Cancer (Location: _____Date: _____) | | | |
| ____ | ____ | Other: _____ | | | |
| ____ | ____ | Drug or Alcohol Dependence | | | |

Present Weight: _____Height: _____ft. _____inches

Have you fallen in the last year? ____No____ Yes (If Yes, approximately how many times?) _____

Medication (Name/Dosage/Frequency/Route administered):

_____

_____

_____

****If you need additional room for medication, please bring a separate document on your next visit**

Hospitalizations/Surgical Procedures (list if not described elsewhere):

_____

_____

_____

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**PATIENT PRIVACY**

Name:_____

DOB:_____

In an effort to comply with current HIPPA (Heath Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person, other than your physician with whom we may discuss your private health information or financial matters.

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

I understand that I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing with me first.

If we are unable to reach you personally, do you give your permission for a staff member of MOVE Physical Therapy and Wellness to leave a message on your answering machine, voicemail or with someone at your home/cell number concerning your private health information or financial matters. (Please check Yes or No).

_____YES _____NO

**Automated Reminders:** Consistency is a vital component to physical therapy. As a courtesy to patients, MOVE Physical Therapy and Wellness will routinely send automated text messages or emails reminding patients of upcoming appointments. Please check one of the following preferences for text or email reminders.

___I prefer to receive reminders via text message at the following number: _____

___I prefer not to receive reminders via text.

_____ _____

**PATIENT SIGNATURE or LEGALLY AUTHORIZED PERSON** **DATE**

_____

**Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)**