TOTAL MOTION PT

1. **Please tell us about yourself:**

First Name: Last Name:

Date of Birth: SSN: Gender: ○ Female ○ Male

Mailing Address: Apt/Unit #:

Mobile Phone: Home Phone: Work Phone:

Email Address: Preferred Appointment Reminder Option: ○ Text Message ○ Email

Primary Care Physician Name: Referring Physician Name:

How did you hear about our office? (Doctor Referral, Website, Facebook, Friend, etc):

If you were referred by MD, friend, family member, etc., please write their name below:

2. **Insurance Information:**

Name of Insurance Company (if you are Self Pay, please write Self Pay):

Subscriber ID #:

Group #:

How is your name listed on the card? Provider Services/Eligibility Phone Number:

If you are a Medicare patient, a referral is required. Please write your referring physician's name:

3. **Secondary Insurance Information (if applicable):**

Name of Insurance Company:

Subscriber ID #:

Group #:

How is your name listed on the card? Provider Services/Eligibility Phone Number:

4. **Diagnosis:**

Where are you having pain/problems (back, neck, shoulders, etc)?

How long has this been going on and how did it originate?

If you didn't have this pain/problem, what could you do more of (sleep, exercise, bend, etc)?

What treatments have you tried so far?

What other injuries/surgeries do we need to be aware of?

Have you ever had Physical Therapy before? If so, did it help?

PATIENT INFORMATION CONSENT

I have read and fully understand Total Motion PT, LLC's Notice of Privacy Practices. I understand that Total Motion PT, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation 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 Total Motion PT, 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 Total Motion PT, LLC's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

CONSENT TO PHYSICAL THERAPY EVALUATION & TREATMENT

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Total Motion PT, LLC. I understand that I will be receiving an initial evaluation followed by one or several treatment sessions. These sessions may include one or more of the following: joint mobilization, soft tissue work, manual therapy, electrical stimulation, ultrasound, heat/ice, traction, passive/active range of motion, strengthening, stretching, exercise, and/or activity of daily living modification. I understand that therapy can be beneficial, but some risks and discomforts may arise. I also understand the risks and consequences of no treatment. I understand that I can discontinue treatment at any time.

RELEASE OF INFORMATION

I hereby authorize release of information necessary to file claims with my insurance company and information to my physician(s). I permit a copy of this authorization to be used in place of the original.

With this consent, **Total Motion PT, LLC** may call and/or text my home or other alternative location and leave a message on voicemail or via text, in reference to any items that assist the practice in carrying out Treatment, Payment and Health Care Operations (TPO), such as appointment reminders, insurance items and any information pertaining to my clinical care, appointments and outstanding balances.

With this consent, **Total Motion PT, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO,such as appointment reminders, insurance items and any information pertaining to my clinical care, appointments and outstanding balances.

With this consent, **Total Motion PT, LLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO,such as appointment reminders, insurance items and any information pertaining to my clinical care, appointments and outstanding balances. I have the right to request that **Total Motion PT, LLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

ASSIGNMENT OF BENEFITS AND INSURANCE PROCEEDS

I hereby authorize payment from my insurance company of medical benefits for services rendered to Total Motion PT, LLC by an assignment of benefits. The completion of insurance forms and the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for physical therapy services rendered.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by Total Motion PT, LLC, regardless of

insurance coverage and whether or not there was an accident with another party at fault. If hospitalization, surgery, or office surgery is indicated, the patient is responsible for furnishing current insurance information to the office prior to hospitalization or surgery.

INSURANCE

Total Motion PT, LLC will file your insurance. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I hereby assign Total Motion PT, LLC any payments of medical benefits for services rendered to myself or dependents.

Copayment/Deductible/Coinsurance: Total Motion PT, LLC is required by your insurance to collect your copayment. If you do not have your copayment your appointment will be rescheduled, unless an exception is made by an owner. I have read and understand that I am responsible for paying the annual deductible, copayment, coinsurance and any charges for non-covered services as determined by my insurance.

OUTSTANDING BALANCES

Total Motion PT, LLC makes every attempt to collect on outstanding balances. If your account goes to collections the 3rd party costs will be added to your account. If your account goes to small claims court, the summons costs, and attorney fees will be added at approximately $300.

I acknowledge that I have read and understand the information above and have asked any questions that I need to ask to understand the above information fully.

Please type or print your name legibly: _____

_____ _____

Client Signature Date

TOTAL MOTION PT

CANCELLATION & NO SHOW POLICY

POLICY ON IF YOU HAVE TO CANCEL AN APPOINTMENT

We understand that there are times when emergencies or obligations for work or family force you to miss a session. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

In order to maintain Total Motion PT's high standard of care, we have implemented a Day Before Cancellation Policy with a cut off time frame. If you must cancel an appointment, you must notify us by 3pm on the day before your appointment. For example, if you are scheduled for 12pm on Thursday, you must notify us by 3pm on Wednesday.

Failure to cancel an appointment by the 3pm cut off time will result in a $25 Cancellation Fee. However, if you add an extra appointment in addition to your regular prescription within the next 7 days as a "make up session," you will not be charged the cancellation fee. For example, you can make up for a cancelled Monday appointment with a Thursday session that week or an extra one for the following week if you were not already scheduled as such. This fee is not covered by insurance.

POLICY ON IF YOU DON'T SHOW UP AT ALL FOR AN APPOINTMENT

We do the best we can with printed schedules and reminders of your appointments, but it is your responsibility to know your schedule and plan to be in the clinic, on time, on those days. If you No Show for an appointment once, you will not be charged but it will be noted in your file. If you No Show for any sessions after the first No Show, a $50 No Show Fee will be charged. This fee is not covered by insurance. That fee must be paid on your next scheduled appointment. If you reach 5 No Shows, your therapist may elect to discharge you from our practice.

Please type or print your name legibly: _____

_____ _____

Client Signature Date

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your treatment and care. Please understand that payment of your services is part of this treatment and care. Payment of all copays, deductibles, and/or coinsurance are due at the time of service.

As a service to you, our office will also call your insurance company to determine the amount due at each visit Our office will also bill your insurance company, if applicable. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances.

Due to the constant changes in health insurance it is your responsibility to know your health coverage. If you should have any questions, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you.

For your convenience, we accept cash, checks, HSA/Flex cards, credit cards (Visa, MasterCard, American Express, Discover) and debit cards.

You will be given a Payment Option Form at your initial visit allowing you to choose your method of payment.

I have read, understand, and agree to the above Patient Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copays, deductibles, and/or coinsurance are my responsibility. I authorize my insurance benefits be paid directly to Total Motion PT, LLC. I authorize Total Motion PT, LLC to release medical information to my insurance company when requested, or to facilitate payment of a claim.

Please type or print your name legibly: _____

_____ _____

Client Signature Date

TOTAL MOTION PT

Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit/debit/flex card information securely on file with Total Motion PT, LLC. In providing us with your card information, you are giving Total Motion PT, LLC permission to automatically charge your card on file for your copay, deductible/coinsurance, (or any other patient(s) you have listed on this form) at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Copays/Deductible/Coinsurance: Due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is an outstanding balance owed, Total Motion PT, LLC will notify you via phone, text and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, and no payment arrangements have been made, any balance owed will be charged to your card. A receipt of this charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize Total Motion PT, LLC to charge copays/deductible/coinsurance and outstanding balances on my account to the following credit card (please circle):

Visa **MasterCard** **American** **Express Discover**

Credit Card Holder's Name (print legibly): _____

Last 4 digits of Credit Card: _____ Expiration Date: _____

If you wish to use this card for other patient(s), please print their names below legibly:

Patient Full Name: _____ Patient Full Name: _____

Credit Card Holder's Signature: _____

Date: _____

This bottom half will be removed and shredded once your credit card information is securely stored.

Full Credit Card Number (please print each number legibly): _____

CVV (3 digit number on the back of card): _____

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of **Total Motion PT, LLC.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research.** We may use and disclose your PHI for research purposes, but we will only do that if the

research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst **Total Motion PT, LLC** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to

tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**

- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

- **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this

notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.

- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

- **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

- **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy by contacting the **Total Motion PT, LLC** office you are receiving services from.

- **Changes to This Notice.** We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

- **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the **Total Motion PT, LLC**, or with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Notice Effective 01/01/2017

TOTAL MOTION PT, LLC

ACKNOWLEDGEMENT OF RECEIPT OF

PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read andr received a copy of the **Total Motion PT, LLC** Notice of Privacy Practices effective January 1, 2017.

Please type or print your name legibly: _____

_____ _____

Client Signature Date