In-Motion PT

Patient Questionnaire

Name:_____

Address: _____

City: _____

Home Phone#:_____Cell Phone#: _____

E-mail:_____

Patient Status: Married_____Divorced_____Single_____Widowed_____Other_____

Employment Status: Full time_____Part time_____Retired_____Student_____Unemployed_____

Date of Birth:_____ Social Security#:_____

Referring Doctor: _____

In case of emergency contact:_____Phone#:_____

Relationship: _____

Have you had Physical and/or Speech Therapy this year? Yes_____NO_____

Are you currently receiving services from any Home Health Agency? ____If yes, who?_____

PATIENT INFORMED CONSENT

I hereby indicate my wish to be a participant in the rehabilitation program offered by In-Motion PT. I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during treatment. I have been informed of the procedures and methods of treatment that will be administered to me, and understand what is required of me as a patient.

I verify that mi participation is fully voluntary and that no coercion of any sort has been used to obtain my participation, and that I may withdraw from treatment at any time.

I understand that the facility administrator maintains an open-door policy and encourages patients to participate in their health care.

For any grievance of any kind, please see Section 504 Grievance Procedure posted in the clinic lobby.

Assignment and release:

I hereby assign my insurance benefits to be paid directly to In-Motion PT. I understand that I am financially responsible for any non-covered services. I also authorize the facility to release any information required to process this claim.

_____ _____

Signature of Patient Date

IN-MOTION PT

Patient Questionnaire

Patient Name: _____

Who is your current treating physician? _____

Have you had any serious illness (es), operations, or been hospitalized in the past five Years? If yes, please describe:_____

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

Yes	No	Diabetes	Yes	No	Hypertension
Yes	No	Allergies	Yes	No	Hearth Disease
Yes	No	Anemia	Yes	No	Pacemaker
Yes	No	Cancer	Yes	No	Circulatory
Yes	No	Liver Disease	Yes	No	Hearing Problems
Yes	No	Respiratory	Yes	No	Visual
Yes	No	Depression	Yes	No	Seizures
Yes	No	Stroke	Yes	No	Drug Abuse

In-Motion PT Attendance policy:

We provide one-on-one care to our valued customers. When you book an appointment for yourself we reserve the time slot for you only, therefore we cannot book another patient for the same time. We have the therapist available for u when you come in to be treated, so please take into consideration these facts when you are unable to attend to your scheduled appointment time. You, as a patient of our facility, are obligated to give us a 24-hour cancellation notice prior to your scheduled appointment time. Failure to do so will result in $15.00 charge, payable by your next scheduled visit.

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 staff responsible for any error or omissions that I have made in the completion of this form.

_____ _____

Patient's Signature (or individual completing this form for the patient) Date

IN- MOTION PT

Patient Questionnaire

Patient Name_____Age_____Date_____

1. What is your primary problem?

_____

_____

_____

_____

2. Do you have any secondary problems?

No_____Yes_____

_____

_____

_____

3. Are you taking any medications for this problem?

No_____ Yes_____

If yes, please explain: _____

_____

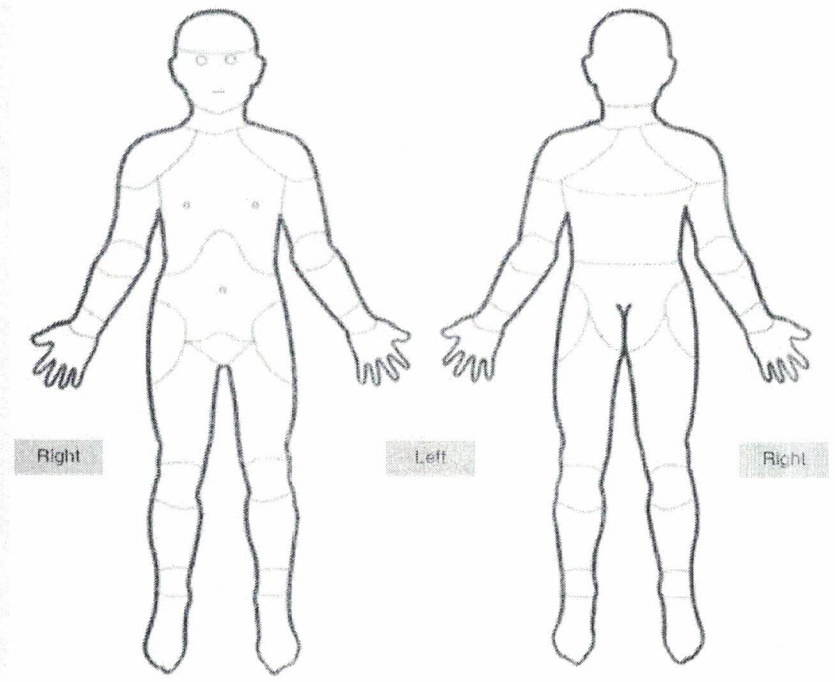
4. Are you taking any other medications?

No_____Yes_____

If yes, explain: _____

_____

_____



In-Motion PT

POLICY AND PROCEDURE MANUAL

Form C1-3C: Patient Questionnaire HIPAA Form

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

Name:_____

Birth date:_____Social Security #_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare options such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory proposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and, and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

I acknowledge that I have received a copy of the organization's Notice of Privacy Practices for Protected Health Information (PHI) under HIPAA.

Patient name printed_____Date_____

Patient/Personal Representative Signature_____

Description of personal representative's authority to act for the patient

_____

Office use only: _____Accepted_____Denied Signature_____Title_____

IN-MOTION PT

Form CI-3E: Do Not Resuscitate Orders

Patient Name:_____

Instructions to the patient: Please sign either (A) or (B):

(A) I wish to have resuscitation in the event of cardiopulmonary arrest (hearth and breathing stops)

_____

Signature **Date**

(B) In the event of cardiopulmonary arrest (hearth and breathing stops), I refuse any resuscitation measures, including cardiac compression, endotracheal intubation and other advanced air way management, artificial ventilation, defibrillation, administration of advanced cardiac life-support drugs and related emergency medical procedures. I understand that death may result from refusing such resuscitation.

_____

Signature **Date**

Hospice program (if any)_____

I was present when this was signed. The patient then appeared to be of sound mind and free from duress.

_____

Signature of Witness **Date**