MOVEMENT WORKS
PHYSICAL THERAPY

6695-Suite 100 East Pacific Coast Hwy.
Long Beach, CA 90803
Tel: 562-596-7074 ● Fax: 562-596-7214
www.movementworks.com

PATIENT DATA SHEET

(Please Print)

Name: Sex: ☐Male ☐Female
First Middle Initial Last

Home Address: Age:
Street City Zip

Email: Driver's License: Date of Birth:

Home Phone: Cell: Work:

Occupation: Employer:

☐Spouse ☐Domestic Partner ☐Responsible Parent:

First Middle initial Last
Home Address: Age: Sex: ☐Male ☐Female
Street City Zip
Date of Birth: Home Phone: Cell:

IN CASE OF EMERGENCY

Name: Relationship:

Address:
Street City Zip
Home Phone: Cell:

PLEASE COMPLETE IF PATIENT IS UNDER 21 YEARS OF AGE OR A STUDENT

Parent or Guardian: Parent or Guardian:

Address: Address:

Phone: Phone:

MEDICAL INSURANCE

Primary Ins. Co: Secondary Ins. Co:

IF ACCIDENT, WHEN AND HOW DID IT HAPPEN
☐Home ☐Recreation ☐Work ☐Automobile ☐Other:

Date of Injury: Hour: Last Worked:

If industrial injury, name, and address of employer at time of injury:

REFERRED TO THIS OFFICE BY:

AUTHORIZATION:

The undersigned patient, or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Movement Works Physical Therapy (MWPT) reserves the right to designate any qualified physical therapist to perform and administer care and treatment of the patient.
2. MWPT is granted permission to release to the insurance carrier, their representatives or referring physician, any information in connection with any treatment rendered to the patient, or in patient's behalf at anytime such information is requested or required by law.
3. Patient shall pay MWPT such sums as they are or become due for any services rendered to the patient, it being understood that in the event a patient's insurance company, if there be any, does not make payment, makes incorrect payment, or only partial payment for any reason, this obligation shall be binding personally upon patient or responsible guardian.
4. I assign payment of all medical benefits to which I am entitled to the office of MWPT.

Patient, Parent, Guardian Date

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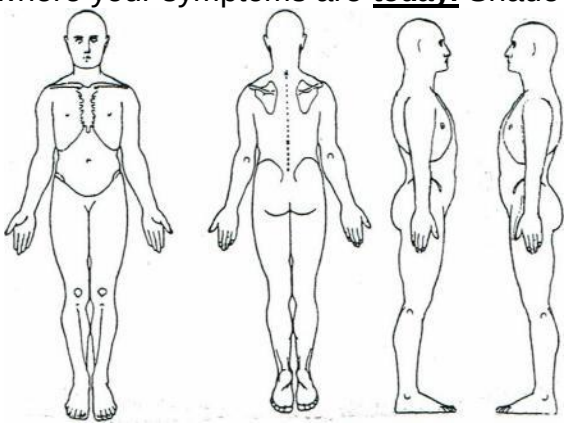
Please shade this drawing where your symptoms are **today.** Shade the worst area darker.



On the scale below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please circle the number below which best represents your overall average level of function:

Cannot do any of My normal activities 0 1 2 3 4 5 6 7 8 9 10 Able to do all my normal activates

My symptoms are currently getting: ☐Better ☐ Worse ☐ Staying the same

What date (approximately) did your present symptoms start? _____

Did your symptoms occur: ☐ Gradually ☐ Suddenly

Were your symptoms a result of: ☐ Injury ☐ Surgery ☐ No apparent reason

What treatments have you received for this problem so far? _____

_____

For this problem, have you had an: ☐ X-Ray ☐ MRI ☐ Other Imaging (CAT Scan, etc.)

What makes your symptoms better? _____

What makes your symptoms worse? _____

Please identify up to 3 important activities you are unable to do or are having difficulty with:

1 _____

2 _____

3 _____

What are your goals for therapy?

_____

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PATIENT MEDICAL HISTORY

Name: _____ Age ____Height __ Weight ___Date_____

Gender: M / F Smoker: Y / N Pregnant: Y / N Exercise (≥ 3x/week): Y / N

Past surgical history (list and date):_____

_____

Current medications (list):_____

_____

How are you sleeping? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication

Past Medical History					
Condition	Yes	No	Condition	Yes	No
Cancer			Osteoporosis		
Diabetes			Osteoarthritis		
Kidney Disease			Rheumatoid Arthritis		
Liver Disease			Polio		
Stroke			Rheumatic Fever		
High Blood Pressure			Epilepsy or Seizures		
Heart Disease			Allergies		
Angina or Chest Pain			Lung Disease		
Ulcers			Parkinson's Disease		
Lupus			Pacemaker		
Blood Thinners			Asthma		
HIV/AIDS			Hepatitis		

In the past 3 months have you had, or do you experience:

Symptom	Yes	No	Symptom	Yes	No
Fever/Chills/Sweats			Poor Balance		
Change in appetite			Difficulty swallowing		
Numbness and/or tingling			Headaches		
Unexplained weight change			Upper respiratory infections		
Change in bowel/ bladder			Increased pain at night		
Urinary tract infection			Under an unusual amount of stress		
Nausea or Vomiting			Dizziness or lightheadedness		
Depressed			Shortness of breath		
Recent illness			Falls		
Recent hospitalization			Visual disturbances (blurred,		

Date of your last complete physical examination:_____ Year:_____

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PAYMENT POLICY AND PATIENT RESPONIBILITY

To meet the need of our patients, we participate in many insurance programs. Each insurance company has its own specific rules regarding the level of care, the amount of reimbursement and the physical therapy practice where you may obtain care. While we will work with you to provide your care within the guidelines of your plan, our main concern is providing you with comprehensive, compassionate, and exceptional physical therapy care.

1. **INSURANCE**. **(Knowing your insurance benefits is your responsibility.)** We participate with some, but not all insurance companies. We make every attempt to verify your coverage with your carrier and inform you of your deductible and co-payment responsibilities. We verify benefits as a courtesy to our patients and we are at no time to be held responsible if incorrect information has been obtained. Please remember that the information we get from your carrier is only an estimate, and we can not be sure of the exact amount until we submit a claim and receive an Explanation of Benefits. Be aware that verification of insurance benefits is not a guarantee of payment. Payment by your insurance will be determined once your claim is received. Your insurance company will process your claims as in or out of network according to your insurance policy.

   Initials_____

2. **CO-PAYMENTS and DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payments, deductibles, and co-insurance are the patient's responsibility.

   Initials_____

3. **NON-COVERED SERVICES.** Please be aware that some or all services provided to you during your visit may not be covered by your insurance company. Any unpaid services are patient responsibility and payment may be required in full at the time of the visit. You are also responsible for payment for any supplies you receive the day you receive them.

   Initials_____

4. **PROOF OF INSURANCE.** All patients must complete the patient intake forms before receiving any services through our facility. We also require a copy of a valid photo ID, such as state license, and a copy of your current insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim

   Initials_____

5. **CLAIMS SUBMISSION.** Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims to both your primary and secondary insurances. Some insurance companies require patients to submit information directly and if so, this is your responsibility to do so in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Any unpaid balances remaining 60 days after claims have been submitted to your insurance become your responsibility.

   Initials_____

6. **COVERAGE CHANGES.** It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failing to do so may result in unpaid claims and you may be responsible for the balance of the claim in full.

   Initials_____

7. **NONPAYMENT.** If your account is over 30 days past due and arrangements have not been made, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless satisfactory arrangements have been made with our billing department. If balances remain unpaid, we may refer your account to a collection agency, which will result in up to 50% of the unpaid balance in additional collection fees. If you pay with a check and your check is returned, your account will be reviewed, and you may be charged a **$35.00 Returned Check Fee.** If it becomes necessary to commence legal action, you are responsible for all costs of collecting moneys owed including court cost, collection agency fees and attorney fees in addition to your outstanding account balance.

   Initials_____

8. **NO-SHOWS or CANCELLATIONS.** There will be a charge of $35.00 dollars for No-Show appointments and Cancellations with less than 24-hour notification. You are personally responsible for any No-Show and Cancellation fees.

   Initials_____

I have read, understand, and agree to the provisions of this policy.

_____ _____
Patient Name (print) **Date**

_____
Patient or Legally Authorized Representative Signature

_____ _____
Legally Authorized Representative (print) **Relationship to Patient**

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ACKNOWLEDGEMENT FORM
CONSENT TO TREAT & "NOTICE OF PRIVACY PRACTICES"

I, the undersigned, hereby agree and give my consent for Movement Works Physical Therapy, Inc. to furnish care and treatment considered necessary and proper in treating my condition.

I have been presented and had an opportunity to review the "Notice of Privacy Practices". I understand that the "Notice of Privacy Practices" is available for additional review during business hours and that I may have a personal copy upon request.

(Print Patient Name) (Signature patient/guardian) (Date)