Name Last_____ First _____ MI ____ *Date*_____

Parent / guardian name(s) (if patient is a minor) _____

*Current/Permanent address*_____

City _____ *State* _____ *Zip* _____

Phone **Cell** *(_____)*_____ **H**(_____)_____ **W** (_____)_____

Which, of the above, phone number is preferred/primary? ❒ Cell ❒ Home ❒ Work (check one)

*Date of Birth:*_____ *Age:*_____ *Gender* ❒ Male ❒ Female *Marital Status* ❒ Single ❒ Married

*Social Security Number:*_____ *Drivers License #:*_____

Employment Status: ❒ *F/T* ❒ *P/T* ❒ *Not working* ❒ *Student* *Occupation:* _____

*Name of Employer: (if applicable)*_____

Employer's Address: _____

Emergency Contact:_____ _____ (____)_____
[Name] [Relation to patient] [Phone]

Referring Provider _____ *Family Doctor*_____

How did you learn of our practice? **Check one**: Physician ❒ Yelp ❒ Google ❒ Yahoo ❒ Insurance List ❒

Family/Friend ❒ , _____ Other: _____

Have you had PT or Acupuncture at another clinic this year? Yes ❒ No ❒ If yes, approx. how many visits?_____

Is your injury an Auto, Personal, or Work Injury? *Yes* ❒ *No* ❒ ***If yes, which one?:*** ___ Auto ___ Work ____ Personal

Your Medical/ Health Insurance (please fill out even if you provided insurance card(s))_____

Who is responsible for the account? ***Yourself?*** *Yes* ❒ *No* ❒ *If no, please fill out below in this section.*

Primary insurance card holders NAME: *Last* _____ *First*_____

Primary insurance card holders Date of Birth*:* _____ *Relationship to patient?*_____

Address ____ *(if same as above, check here)* _____

Primary Insurance company name _____*PPO*__*HMO*__*Other*_____

Secondary Insurance company (if applicable) _____*PPO*__*HMO*__*Other*_____

Please complete the section below ONLY if your injury is WORK, AUTO, or PERSONAL INJURY:

Date of Accident / Injury: _____ ***Claim #:*** _____

Adjuster's Name: _____ *Adjuster's Phone Number: (_____)*_____

Do you have an Attorney? Yes ❒ *No* ❒ *May we have permission to speak with him/her regarding your treatment and payment at Made to Move Physical Therapy, Inc.? Yes* ❒ *No* ❒

If Yes, Name _____*Phone Number (_____)*_____

ONLY COMPLETE THIS SECTION IF AUTO or PERSONAL INJURY

Which Auto insurance company is handling the medical expenses for your injury? ❒ *Yours* ❒ *Other Party*

Auto Insurance Company Name (handling the medical claims) : _____

Has Fault Been Established? Your Fault? _____ *Other Party?* _____ *Both?* _____

Auto Insurance Policy Holder's Name _____

Do you or the other party have MEDPAY as additional coverage on the auto insurance policy? Yes ❒ *No* ❒

*Patient Name:*_____ *DOB:* _____

Assignment of Benefits: ***(MUST BE SIGNED IN ORDER TO BILL YOUR INSURANCE FOR SERVICES PROVIDED)***
I hereby assign payment directly to Made to Move Physical Therapy, Inc. who represents this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I will update billing information in writing to Made to Move Physical Therapy, Inc. as soon as any changes occur in my insurance coverage or address.

AUTO: I understand that if this is a motor vehicle accident and the AUTO medical benefits are exhausted, I will be financially responsibility for any non covered services.

X_____ _____ _____
Signature of patient or responsible party **Date** Relationship to Patient

Medicare and Medicare Supplemental Insurance **(ONLY COMPLETE IF YOU HAVE MEDICARE INSURANCE)**
I request that payment of authorized Medicare benefits be on my behalf to Made to Move Physical Therapy, Inc. for any services furnished to me by that provider. I authorize any custodian of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I herby give Made to Move Physical Therapy, Inc. permission to bill for Medicare Supplemental Insurance payments for my medical care. I request that payment of authorized Medicare Supplemental benefits be made on my behalf to Made to Move Physical Therapy, Inc. for any services furnished to me by that provider.

X_____ _____ _____
Signature of patient or responsible party **Date** Relationship to Patient

CONSENT FOR TREATMENT / RELEASE OF INFORMATION FROM YOUR DOCTOR'S OFFICE

Release of Information: I authorize _____,MD / DPM / PA / NP (your provider's name) to release any of my medical records, imaging, or surgical reports to Made to Move Physical Therapy, Inc. for the purpose of obtaining medical information pertaining to my treatment.

Consent for Treatment and Prescriptions: I, the undersigned, do hereby agree and give consent for Made to Move Physical Therapy, Inc. to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical therapy condition(s). Treatment is administered based on the physician's diagnosis and requires a prescription throughout the plan of care. It is my responsibility, as the patient, to provide Made to Move Physical Therapy with these prescriptions, as needed.

Consent to Share Medical and/or Billing Information: In the event that our staff may need to discuss medical or billing issues with you or your family, please provide the name(s) of those with whom we may speak and phone #(s). This allows us to maintain your privacy.

Names: _____

Authorization to Treat a Minor: I, _____, the parent or guardian of _____, a minor under the age of 18, permit the healthcare professionals at Made to Move Physical Therapy, Inc. to evaluate and treat the above referenced minor.

X_____ _____ _____
Signature of patient or responsible party **Date** Relationship to Patient

Patient Name:_____ DOB: _____

POLICIES AND PROCEDURES REGARDING PAYMENT ON YOUR ACCOUNT

INSURANCE CARDS: We will need a copy of your insurance card(s) in order to bill your insurance carrier for services rendered at MTMPT. It is your responsibility to notify and provide us with any insurance changes. **You may be charged an additional fee for failure to provide correct insurance coverage at the time services are rendered.** Initial here_____

Cancel or No Show: In lieu of charging a no-show or cancellation fee, if you no-show or late cancel (<24 hours) for 2 consecutive treatments, all future appointments will be canceled; you will have to call for a same day appointment only. We have 24 hour voicemail system to leave a message. We may have patients waiting for appointments on the waitlist. Your courtesy of a phone call and consistency will allows us to schedule other patients in need**.** Initial here _____

Insurance Billing: Billed charges ARE PRIOR to any negotiated in-network contract adjustment applied by your insurance company. THE NEGOTIATED RATE IS A DISCOUNTED REIMBURSEMENT RATE THAT IS DIFFERENT FOR EACH INSURANCE CARRIER. It is YOUR responsibility to ask the front desk staff for the details of your physical therapy benefits, **although** this is not a guarantee of benefits. It is ultimately **your** responsibility to know and verify physical therapy benefits from your insurance company.

As a courtesy to you, we will bill your insurance carrier each week and make every reasonable effort to assist in expediting insurance payment. Some insurance companies pay claims quickly and completely; some pay slowly and only in part or not at all. ***You are ultimately responsible in making sure your insurance company releases payment.*** *Authorization for payment goes directly to Made to Move Physical Therapy, Inc. otherwise payable to you for services rendered.*

Initial here _____

Co-pays / Co-Insurance / Deductible payments are due at time of service. Our front desk will verify your insurance benefits and provide you with a detailed benefit letter explaining your patient financial responsibility each visit, including up-to-date remaining policy year benefits, visit limits, remaining deductible and out of pocket max responsibility. Failure to meet your financial responsibility for payment or to make special arrangements if you cannot make payment may cause treatment to be discontinued. Initial here _____

Accounts Payable: Upon completion of your course of treatment, any remaining balances are due and payable within 60 days, unless special arrangements have been made. If a refund is due back to you, Made to Move PT will issue you a check within 60 days of receiving the last insurance explanation of benefits.

I am financially responsible for any applicable deductibles, co-insurances, or co-pays. I also understand that I am financially responsible for any charges beyond my insurance benefit coverage (ie., visits or $ amount exceeding yearly benefit maximum). I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. Initial here _____

If you have any questions or need to make special arrangements, please notify us immediately.

Acknowledgement of responsibility by patient or guardian of patient.

The undersigned accepts financial responsibility to Made to Move Physical Therapy, Inc. for services rendered under the terms listed above. Should the account be referred for collection or legal matters, the undersigned will pay collection, legal and/or attorney fees/expenses.

I have read the information above and understand that I am solely responsible for payment on my account.

X_____ _____

Patient Signature (if minor, signature of parent/guardian) Date

Patient Name:_____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES (HIPAA)

I have read and fully understand Made to Move Physical Therapy's Notice of Information Practices. I understand that Made to Move Physical Therapy may use or disclose my personal health information for the sole 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 Made to Move Physical Therapy 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 Made to Move Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I, _____, have received the Notice of Privacy Practices from Made to Move Physical Therapy.

X _____**Date:**_____
Patient Signature

X _____
Signature of Parent/Guardian(if patient is a minor)

IN LIEU of patient signature, I, _____, a staff member of Made to Move

Physical Therapy, state that_____ (patient's name) has been given our current Notice of Privacy Practices.

X _____ **Date:** _____
(Staff Member's Signature)

EMAIL and CELL PHONE COMMUNICATION CONSENT

May we send an EMAIL appointment reminder 24 hours before your scheduled appointment? *Yes* ❒ *No* ❒

How do you want to receive, if any, your invoice(s)/ statement(s)? ❒ EMAIL ❒ MAIL ❒ BOTH (check one)

Email address: (please print clearly) _____
(Regarding email privacy: your email address remains confidential with Made to Move PT. Your information is never released to any 3rd party without your consent.)

May we TEXT your cell for emergency / last minute cancellations or appointment changes? *Yes* ❒ *No* ❒

Which phone number(s) may we leave a voice mail? ❒ *Cell* ❒ *Home* ❒ *Work* *(check all applicable)*

Patient Name: _____ Date of Birth: _____

THIS PAGE IS INTENDED FOR MEDICARE PATIENTS ONLY!

As of the year **2025**, the Medicare therapy cap for **combined** inpatient and outpatient rehabilitation coverage for Physical Therapy AND Speech Therapy is **$2,410** per beneficiary for the calendar year. Keep in mind that the **$2,410** includes both the amount Medicare pays and the beneficiary copayment. Once you've hit the cap amount, you can either pay out of pocket for your services at our facility or receive physical therapy services in an outpatient hospital setting.

Medicare DOES NOT pay for therapy services that aren't medically reasonable and necessary. In other words, **Medicare DOES NOT pay for MAINTENANCE therapy**. The (ABN) Advance Beneficiary Notice of Noncoverage lets you choose whether or not you want the therapy services. If you choose to get the services, you agree to pay for them if Medicare doesn't pay. If you get therapy services that aren't medically reasonable and necessary and Medicare doesn't pay for them, you won't have to pay for the services unless an ABN was given to you beforehand.

In order to be compliant with these guidelines, please provide the following information:
Have you received **ANY** PHYSICAL THERAPY and/or SPEECH THERAPY **this calendar year**?

❒YES ❒ NO If YES, approximately how many visits? _____

At what facility did you receive these services? _____

In order to be eligible for outpatient physical therapy services under Medicare Part B, you must not live in a skilled nursing facility or be receiving any home health services, including physical therapy and/or nursing.

Are you currently living in a skilled nursing facility? ❒YES ❒ NO _____

Are you currently receiving home health services (Includes any nursing care) ? ❒YES ❒ NO

If YES, what is the name of the Home Health Agency providing these services?

Patient Signature: _____ **Date :** _____

Made To Move
physical therapy, inc

Medical History

Name: _____ Date of Birth: _____ Age: _____

When did your symptoms start? _____

Are your symptoms: ____Improving ____Getting Worse ____Staying the Same

Briefly describe the current problem that brought you here: _____

_____

Where were you injured? ____Work ____Home ____Motor Vehicle Accident ____ Other: _____

Did you have surgery for this condition: ____Yes ____No Date of Surgery: _____

If yes, what surgery did you have done? _____

Describe previous treatment for this condition:_____

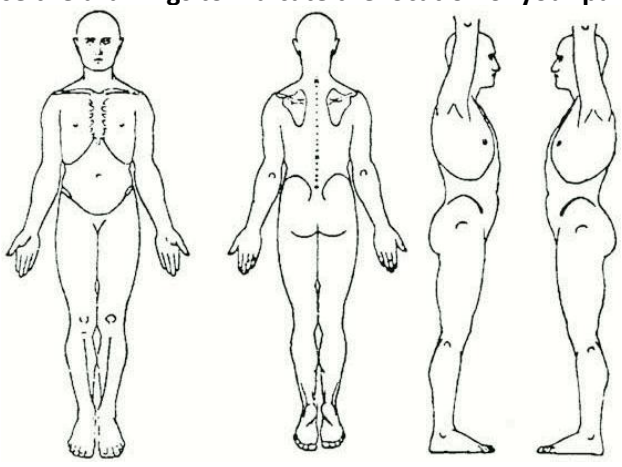
Diagnostic imaging or studies completed for this condition? ___X-Ray ____MRI _ __CT Scan

____EMG or Nerve Conduction Study Imaging findings?: _____

Where's your pain/injury/symptoms located? _____

Please use the drawings to indicate the location of your pain/injury

Drag circles to areas of pain:



Drag circles to rate your pain:

Rate your pain (1=minimal 10=severe): **At worst: 1 2 3 4 5 6 7 8 9 10 / At best: 1 2 3 4 5 6 7 8 9 10**

What were you doing prior to this injury that you are unable to do currently? _____

_____

Check all current FUNCTIONAL LIMITATIONS as a result of your current condition:

___Squatting	___Stairs	___Dressing / Grooming
___Sitting	___Position Changes	___Reaching
___Standing / Walking	___Work tasks	___Gripping/pinching
___Kneeling	___Bending	___Holding/carrying objects
___Driving	___Lifting	___Pushing / Pulling

Check any other RECENT symptoms: ___Weight Gain / Loss ___Nausea / Vomiting ___Fatigue ___Weakness

___Fever / Chills / Sweats ___Numbness / Tingling ___Pregnant ___Headaches ___Insomnia

___Change In Vision Or Hearing ___Pain At Night ___Cramps In Legs When Walking

Medical History

Please list all present medications that you are taking including *dosage and frequency*:

_____

_____

Please list PAST surgeries or other conditions for which you have been hospitalized: _____

_____

Please check all medical conditions that you have been diagnosed with:

___Heart Disease	___Respiratory Disease	___Thyroid Dysfunction
___Heart Attack	___Pneumonia	___Fibromyalgia
___High Blood Pressure	___Tuberculosis	___Surgical Implants
___Stroke	___Asthma	___Pacemaker
___Epilepsy	___Hepatitis	___Pregnant
___Diabetes	___Anemia	___Anxiety or panic disorders
___Cancer	___Hernia	___ Other:_____

Do you smoke tobacco? ___Yes ___No If yes, how much per day? _____

What are your goals for therapy? _____

_____

Patient Signature: _____ Date: _____

(NOTE: Insurance carriers require a signature)