Move Free Physical Therapy: Intake Form

Please complete all required items below as part of our intake packet.

* Required

1. Patient Name *

   Please Type the Patient's Legal First and Last Name

2. Date of Birth *

   Example: January 7, 2019

3. Email Address

4. Phone Number *

5. Physical Address *

6. Primary Care Provider and Practice Location *

7. Emergency Contact Information

Please give your emergency contact's name, relationship to patient, and best contact number

8. Reason for Therapy *

9. Medication List

Includes prescriptions, OTC, herbals, etc used regularly (feel free to leave blank if you have a printed copy for me to scan in person)

10. Have you had any testing or treatment for this issue before

Mark only one oval.

- Yes
- No
- Other:

11. Past Medical History

Please Check All that apply (we will discuss details in person)

Check all that apply.

- [ ] Allergies
- [ ] Arthritis
- [ ] Blood or Circulation Disorders
- [ ] Bowel or Bladder Issues
- [ ] Cancer
- [ ] Depression/Anxiety
- [ ] Diabetes
- [ ] Dizziness or Fainting
- [ ] Seizures
- [ ] Gout
- [ ] Head Injury
- [ ] Headaches
- [ ] Hearing impairment
- [ ] Heart Problems
- [ ] High Blood Pressure
- [ ] Infectious Diseases
- [ ] Kidney Disease
- [ ] Lung Conditions
- [ ] Neurological conditions (stroke, Parkinson's, MS, etc)
- [ ] Numbness or Tingling
- [ ] Osteoporosis
- [ ] Pregnancy (current)
- [ ] Shortness of Breath
- [ ] Sleeping Problems
- [ ] Thyroid Problems
- [ ] Tobacco Use
- [ ] Unintentional Weight Loss
- [ ] Visual Impairment

12. Please use this space to list any additional information about your health conditions or applicable surgical history.

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13. What do you hope to achieve with Physical Therapy?

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Policy Agreements

Financial Responsibility Policy

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. I am responsible for charges incurred, regardless of insurance coverage. See rate sheet for current rates. If Move Free Physical Therapy at Home has a contract with my insurance carrier, Move Free will file the claim for your services. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I understand that I am responsible for all balances due. Move Free Physical Therapy at Home accepts assignments for Medicare B patients and provides out of network/private pay services.

I understand, in some instances, some or all of the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I understand that it is my responsibility understand my insurance benefits and comply with the requirements of the policy.

I understand, in some instances, my secondary insurance provider may send me a check for the co-insurance and deductible. In this case, Move Free Physical Therapy at Home may collect an estimated co-insurance up front, or bill me for this at a future date.

14. Financial Agreements *

By clicking the check box next to the fields below, I am agreeing to their contents.

Check all that apply.

- [ ] I agree to be responsible for any portion of my bill not covered by insurance.
- [ ] Medicare Recipients: Please check this box to verify your consent for us to bill and be paid by Medicare for PT services
- [ ] Other Insurance Recipents: Please check this box to verify your consent for us to bill your insurance for POSSIBLE out of network reimbursement as a convenience
- [ ] All Patients: Please check this box to indicate you understand and agree to the Financial Responsibility Agreement

Appointments and Scheduling Policy

All appointments are expected to be approximately 60 minutes in length unless otherwise noted. You will receive an automated reminder prior to your appointment.

Move Free Physical Therapy at Home respects your time and makes every effort to arrive on schedule. However, because therapists cannot anticipate what every client will need, or in the case of medical emergency, they will take whatever time is needed to give each patient the care they need.

As Move Free therapists makes home visits, challenges in parking, heavy traffic, or unforeseen road conditions may also impact arrival time. For this reason, please allow therapists will give a window of 15 minutes before or after the appointment time of arrival. If therapist is running more than 15 minutes late, you will be called and given the opportunity to reschedule without a cancellation / no show fee if needed.

15. Appointments and Scheduling Agreement *

Mark only one oval.

( ) I have read, agree with, and understand the above information regarding appointment times and procedures should the therapist be running late

Cancellation/No-Show Policy

If you are unable to keep an appointment, please contact your therapist as soon as possible.

E-mail is a suitable means to communicate visit cancelation if the message is sent more than twenty-four hours prior to visit start time, otherwise please text or call the main number.

Late cancellation fees are as follows and will be billed directly to the client (not insurance)
Less than 24 hours' notice: $25
Less than 4 hours' notice or no-show: $50

The cancellation fee MAY be waived in case of true emergencies.

16. Cancellation/No-Show Policy Agreement *

Mark only one oval.

◯ I have read, agree with, and understand the cancellation policy

Informed Consent Policy

Physical Therapy involves the use of many different types of physical evaluation and treatment. Please understand that a Physical Therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging, and that health plan or insurer might not cover such services.

As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely between people, it is not always possible to accurately predict your response to a certain modality or procedure, and it cannot it be guaranteed that the treatment will help the condition you are seeking treatment for. There is also a small risk that the treatment may cause pain or injury or may aggravate previous existing conditions.

You have the right to ask the physical therapist what type of treatment they are planning based on medical history, diagnosis, symptoms and testing results. You may ask the therapist about the potential risks and benefits of any specific treatment. You have the right to decline any portion of the treatment at any time before or during the treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Any exercise has inherent risks, so if you have any questions regarding the type of exercise that you will be performing and any specific risks associated with these exercises, the therapist will be glad to answer them.

I acknowledge that I understand my rights as a patient, that my therapist will explain my treatment program, and all my questions have been answered to my satisfaction. I understand the risks and benefits associated with a program of Physical Therapy, and consent to treatment.

17. Informed Consent Agreement *

Mark only one oval.

◯ I agree to the above statements, acknowledge the possible risks and benefits to physical therapy, and consent to treatment.

18. Patient Media Release *

I hereby grant permission to the staff of Move Free Physical Therapy at Home to use images, likenesses, audio or any other data (heretofore referred to as "Media") obtained through my treatment for instructional, educational or research purposes. This included all photos, videos, audio recordings, or any other data obtained by or submitted to the staff of Move Free Physical Therapy at Home in the course of my treatment. The Media may be used in any professional manner that the business owner deems necessary. I understand that the Media belongs to Move Free Physical Therapy at Home, and I will not receive any compensation or payment in connection to its use. I assume the risks involved in releasing this information and release Move Free Physical Therapy at Home and it's employees and contractors from any and all liability that could arise from the use of this Media.

Mark only one oval.

- ◯ Yes I agree to allow media participation
- ◯ No, I wish to opt out of any media participation

Patient Privacy and HIPAA Policy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent (located at https://www.movefreeptnc.com/new-client-info) I understand that Move Free Physical Therapy at Home has the right to change their Notice of Privacy Practices from time to time and that I may contact Move Free Physical Therapy at Home at any time to obtain a current copy of the Notice of Privacy Practices.

I fully understand that Move Free Physical Therapy at Home may use or disclose my personal health information, without limitations, for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, patient trend studies 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 Jessica Tomkoski PT, DPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge and permit the use and disclosure of my personal health information for purposes described above, and acknowledge my right to revoke this agreement by notifying the practice in writing at any time.

19. Patient Privacy and HIPAA Acknowledgement *

Mark only one oval.

- ( ) I have read, agree with, and understand the statements regarding the privacy policy above.

20. Consent to contact via email/text *

Patients in this practice may be contacted via e-mail and / or text messaging to be reminded of an appointment, to obtain feedback on their experience with this healthcare team, and / or to provide general health reminders / information. If at any time you provide an e-mail or text address at which you may be contacted, you consent to receiving appointment reminders and other healthcare communications/information at that e-mail or text address from Move Free Physical Therapy at Home staff. You may revoke this consent in writing at any time. We do not charge for this service, but standard text messaging rates may apply as provided in the patient's wireless plan (contact cell carrier for pricing plans and details).

Mark only one oval.

- ( ) YES, I consent to email and text reminders and communications
- ( ) NO, I do not want email and text reminders or communications
- ( ) Other: ____________________

21. Policy Acknowledgement for Concerns *

If you are concerned that your therapist has violated privacy rights or if the patient or caregiver disagree with any decisions we have made, please contact Dr. Tomkoski, owner, 919-886-4163 or movefreeptnc@gmail.com. She will work with you to address your concerns and take appropriate action.

Mark only one oval.

- ( ) I have read, agree with, and understand the above statements, and how to make my complaints known.

22. Electronic Signature *

By typing my name here, I agree that I am the patient or the patient's legal representative, and my answers above are true. You can access policy documents for your records at www.movefreeptnc.com/new-client-info.

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23. Today's Date *

Example: January 7, 2019

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