ProMotion
REHAB AND SPORTS MEDICINE

GENERAL HEALTH QUESTIONNAIRE

PATIENT NAME:	**DOB:**	**AGE:**	**GENDER:** M/ F	**SSN (for insurance purposes):**
Address:				**Best Contact Number for Appointment Reminders:**
Preferred Method of Appointment Reminder (circle one): TEXT or CALL	**Email Address:**			
Emergency/Secondary Contact Name:	**Phone #:**			**Relationship**:

MEDICAL HISTORY: (Check all that apply)

____ **High Blood Pressure** _____ **Thyroid Disease** _____ **Osteoarthritis**

____ **Diabetes** _____ **Kidney Disease** _____ **Rheumatoid Arthritis**

____ **Heart Disease** _____ **Liver Disease** _____**Sexually Transmitted Infection**

____ **Lung Disease** _____ **Stroke/TIA** _____ **Pacemaker**

____ **Osteoporosis** ---------- Last bone density scan: _____

____ **Cancer** ---------- Date Diagnosed: _____ Area/Type/Metastasis: _____

Are you undergoing active treatment or in remission? _____

Have you had a **recent illness**? If so, explain: _____

Are you currently **pregnant** or **breast-feeding**? _____

Are you experiencing any of the following (check all that apply):

____ Shortness of Breath/Dyspnea ____ Chest Pain ____ Headaches

____ Dizziness ____ Fainting spells/Syncopy ____ Frequent Falls

____ Nausea/Vomiting ____ Bowel/Bladder Changes ____ Difficulty swallowing

____ Unexpected Weight Loss/Gain _____Numbness/tingling

____ Depression/Mood swings _____Fever/chills/sweats

____ Increased Pain at night _____ Appetite Changes

For Staff to Complete:

Patient Height (in): _____

Patient Weight (lb): _____

ProMotion
REHAB AND SPORTS MEDICINE

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something for which you would like help? YES YES, but not today NO

Past Surgeries and Year performed:

1. _____
2. _____
3. _____

Please list all **allergies**, including **latex**: _____

SOCIAL HISTORY:

Number of family living with you: _____ Do you have stairs in your home or to get inside your home? _____

Occupation: _____ Are you currently not working due to your injury/pain? _____

Do you Smoke and how often? _____ Do you exercise and how often? _____

REASON FOR VISIT:

Where are you currently having pain? _____

Approximately when did your pain start? _____ Was it **gradual**, **sudden** or due to **specific injury** (circle)?

My symptoms are currently (circle the most appropriate answer): **Getting Better** **Getting Worse** **Staying the Same**

What is your personal goal for therapy, aside from decreasing pain? _____

_____

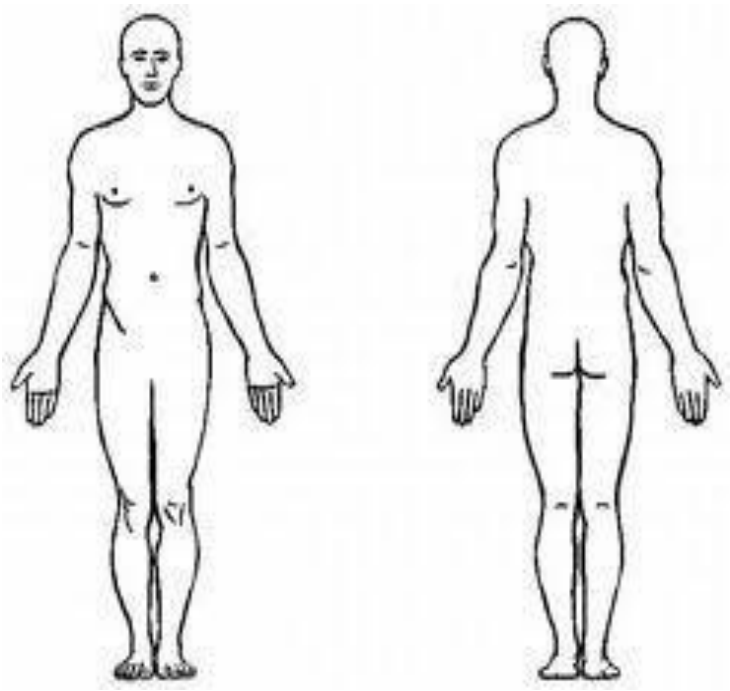
Payments:

I would like to discuss financial hardship or a payment plan with a staff member for my physical therapy program. _____Yes _____No

ProMotion
REHAB AND SPORTS MEDICINE

Pain Drawing: Please indicate your symptoms using the body chart and symbols.

X = Pain **T = Tingling** **N = Numbness**



Pain Rating (on a scale of 0-10) **In the last 24 hours : Now: _____ Lowest level_____ Highest level_____**

0	1	2	3	4	5	6	7	8	9	10
None		Min			Mild			Mod		Severe

_____

_____

For the Therapist:

+ / - Cough/Sneeze
+ / - Saddle Anesthesia
+ / - Bowel/Bladder
+ / - Numbness/Tingling

Severity:
Irritability:
Nature:
Stage:
Stability:

Aggravating Factors:

Easing Factors:

ProMotion
REHAB AND SPORTS MEDICINE

Consent for Care and Treatment

I, the undersigned, do hereby **agree and give my consent for ProMotion Rehab and Sports Medicine to furnish the medical care and treatment considered necessary and proper in assessing or treating** (write in patient name)_____'s physical and mental condition.

Patient/Guardian_____ **Date:** _____

Benefit Assignment/Release of Information

I hereby **assign all medical benefits to include major medical benefits to which I am entitled, including that from Medicare, Medicaid, private insurance and third party payers to ProMotion Rehab and Sports Medicine.** A photocopy of this assignment is to be considered as valid as the original**. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.**

Patient/Guardian_____ **Date:** _____

Financial Policy Statement

ProMotion Rehab and Sports Medicine will **bill your insurance carrier solely as a courtesy to you**. **You are responsible for the entire bill when the services are rendered.** We require **that arrangements for payment of your estimated share be made today.** If your **insurance carrier does not remit payment within 60 days, the balance will be due in full from you.** In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. **In the event your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining**.

If your insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit same to ProMotion Rehab and Sports Medicine.

The above does not apply for those claims considered under Worker's Compensation. However, be advised that if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to ProMotion Rehab and Sports Medicine, including court costs, collection agency fees and attorney fees.

Estimated Insurance Benefits: _____

Estimated patient payment: _____

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party signature **Date**

_____ _____

ProMotion Rehab and Sports Medicine Representative/Witness Date

ProMotion
REHAB AND SPORTS MEDICINE

PATIENT AGREEMENT

- **Patients who CANCEL LESS THAN 24 HOURS IN ADVANCE or who NO CALL/NO SHOW an appointment will be CHARGED $60.00.** We have many patients who are in need of our care, and it is very difficult to fill an appointment time that has been canceled with short notice. In order to be able to assist other patients who may be waiting for a certain time slot to open that will accommodate their schedules, **please give us at least 24 hours' advanced notice if you need to cancel** so that we may offer your time to someone else in need.

- If you must cancel an appointment less than 24 hours from your appointment time due to unforeseen circumstances, such as illness or a family emergency, ProMotion Rehab and Sports Medicine may be able to waive the $60 fee at the clinic manager's discretion.

- **LATE DISCLAIMER-** A patient may receive limited treatment time if late for appointment. While we will do everything we can to accommodate you if you are greater than 15 minutes late, ProMotion Rehab and Sports Medicine reserves the right to cancel the appointment if it will excessively interfere with other patients' care.

- Should a patient miss two consecutive appointments without calling to cancel, the patient will be taken off the master schedule and will forfeit all further permanent appointments.

- **Outstanding deductible, co-insurance and same-day cancel/no show fees** will be **billed** directly to patient on a **monthly basis. ALL CO-PAYS are due at time of service** unless other arrangements have been made with ProMotion Rehab and Sports Medicine.

- If any changes are made to patient insurance/payment coverage, patient agrees to notify ProMotion Rehab and Sports Medicine as soon as possible of these changes.

- **PLEASE INFORM THE FRONT DESK STAFF OF ALL SCHEDULING CHANGES.**

_____ I understand that **I will pay all treatment fees directly to ProMotion Rehab and Sports Medicine**.
(Initial)
_____ I understand that **I am responsible for my deductible, co-pays and same-day cancel/no-show fees**.
(Initial)
_____**I agree to treatment on the above terms**.
(Initial)

Print Name_____ Date_____

Signature_____

ProMotion
REHAB AND SPORTS MEDICINE

PATIENT HIPAA AWARENESS AGREEMENT

With my permission, **ProMotion Rehab and Sports Medicine (The Practice) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).** Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices (at the front desk) was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

_____
(Initial)

With my permission, the offices of ProMotion Rehab and Sports Medicine may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care, including laboratory results among others.

With my permission, the offices of ProMotion Rehab and Sports Medicine may **mail to my home, or other designated location, any items that assist The Practice in carrying out TPO**, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. **I have the right to request that The Practice restrict how it uses or discloses my PHI to carry out TPO.** However, the practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

By signing this form, **I am allowing ProMotion Rehab and Sports Medicine to use and disclose my PHI for TPO.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I may make the following special request for confidential communications:

_____

_____

Please designate any persons that you authorize access to your Personal Health Information here: _____

_____ _____/_____/_____
Signature of Patient or Legal Guardian **Date**

_____
Print Patient's name

_____ _____/_____/_____
Print Legal Guardian's name Date

ProMotion
REHAB AND SPORTS MEDICINE

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed , and how you get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize the laws are complicated, but we must provide you with the following information.

Use the discloser of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosers to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs. Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact your home rather than at work. We will accommodate reasonable requests.
2. You can request restriction in our use or disclosure of your health information for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health care information to only certain individuals involved in your care or payment of your care, such as family members and friends. We are not required to agree to your requests; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must