Patient's History of Current Injury/Illness

ProMotion PHYSICAL THERAPY

Name: _____ **Today's Date**: _____

Age: _____ **Date of Birth**: _____ **Sex**: _____ **Occupation**: _____

Ht._____ **Wt**. _____ **BP**_____ **HR** _____ (office use only)

Are you coming for an injury related to a car accident or a workplace injury? _____

How did you hear about us? _____

History of present condition: (when did your symptoms start, can you identify a cause, have you seen any other health care providers for this issue?)

_____

_____

_____

Chief complaint at this time:

_____

_____

_____

Current functional level (what are you having difficulty with due to pain):

_____

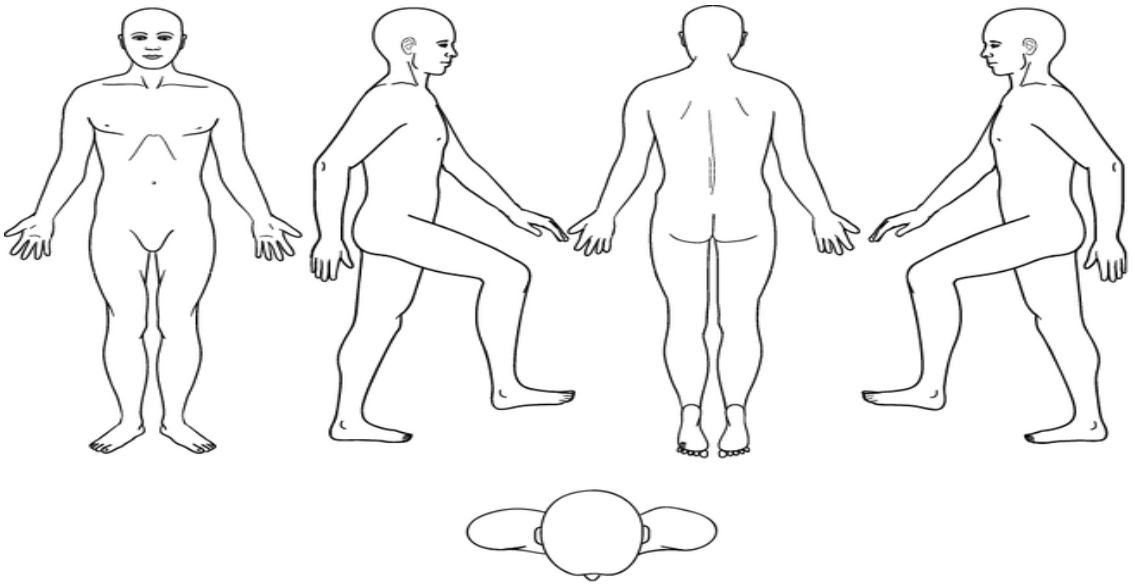
_____

Pain rating*:* Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain free *Unconscious*

Pain



Please use the body diagram to the right and Shade Areas of Pain

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How would you describe your pain? (please check all that apply)

___ Burning
___ Sharp
___ Dull/Achy
___ Throbbing
___ Shooting
___ Numbness
___ Tingling

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes ___ No ____ Describe _____

What activities/positions make your pain worse? _____

_____

What activities/positions make your pain better?_____

_____

Have you had any diagnostic tests? If yes what tests, and what are the findings (ex: X-rays, MRI, bloodwork):

Have you had any falls in the past 6 months? Did it result in an injury?

Please list three functional goals that you have for PT: (ex; walking 30 mins, turning in bed, or reaching top shelf)

1.

2.

3.

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

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If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation _____ (Patient initials)

Medication	Dosage	Reason for Taking

Use additional sheet if more space is needed

Medical History: Please check all categories that apply to your medical history

Condition		Comment/Dates	Condition		Comments/Dates
Respiratory			Stroke		
Cardiac			Seizures		
Pacemaker			Skin Problems		
Diabetes			Psychiatric		
Cancer			HIV/AIDS		
Kidney/Urinary			Hepatitis		
Osteoporosis			Fractures		
Other			Surgery		

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

__Live Alone __Spouse/Significant Other __Child/Children __Other Relative __ Personal Care Attendant __Other

Job Description/Social Activities/Recreational activities: (physical tasks, amount of sitting, lifting, computer work etc.):_____

What are your goals for your course of physical therapy? _____

_____

At the present time, would you say your health is excellent, very good, fair, or poor? _____

_____ _____

Patient Signature Date

Pro Motion Physical Therapy
6849 Old Dominion Dr., Suite 330

McLean, VA 22101

Phone: 703.848.9333

CONSENT TO TREAT / HIPAA RELEASE

CONSENT TO EVALUATION AND TREATMENT
I hereby consent to receive physical therapy evaluation and treatment at Pro Motion Physical Therapy. I acknowledge that no guarantees have been made to me regarding the results of this treatment. I understand that I have the right to ask questions about the treatment provided and to accept or refuse any treatment at any time.

HIPAA RELEASE OF INFORMATION
I understand that I may request a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule from Pro Motion Physical Therapy. I also understand that this information is available online at:

https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveredentities/notice.pdf

I authorize Pro Motion Physical Therapy to release information from my medical record—including written, video, photographic, audio, or verbal documentation—to my referring or treating physician, and to any third-party payers (such as insurance companies or government agencies) for the purpose of treatment coordination, claims processing, and payment.

I understand that this authorization may include information relating to HIV/AIDS, mental health conditions, and treatment for alcohol or drug abuse. I also consent to the use of non-personally identifying information from my medical record for clinical outcomes analysis.

I acknowledge that I have the right to revoke this authorization at any time by submitting a written request to the custodian of records at Pro Motion Physical Therapy. I understand that revocation will not apply to information that has already been released in reliance upon this authorization.

The undersigned certifies that they have read, understood, and accepted the terms of this agreement, and that they are the patient or the legally authorized representative of the patient.

Patient Name (Print): _____

Signature: _____

Date: _____

If Signed by an Authorized Representative:

Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

6849 Old Dominion Dr. Suite #330 McLean, VA 22101
p: 703-848-9333 f: 703-848-0660

Financial Policy Agreement

Welcome to Pro Motion Physical Therapy, LLC. We are dedicated to providing excellent care and want you to understand your financial responsibilities for services rendered.

Out-of-Network Provider Status

We do not participate with any commercial insurance plans. We are a non-participating, non-assignment provider with Medicare, which means we do not accept Medicare's allowed amount as full payment. As a courtesy, we submit claims to commercial insurers and Medicare on your behalf. While commercial patients may choose to submit their claims directly to their insurance carrier, Medicare requires that the provider submit all claims. Regardless of who submits the claim, you remain responsible for all charges associated with your care.

Your Financial Responsibility

● Payment for co-pays, deductibles, and non-covered services is due at the time of service. ● You are responsible for all charges regardless of insurance coverage.
● Insurance denial, delay, or reduction does not waive your responsibility.

Insurance & Referrals

● Confirm your benefits and referral needs directly with your insurer.
● We do not bill third-party liability insurers (e.g., auto or workers' comp).
● If required, please bring a current referral to your first appointment.

Missed Appointments

● Appointments canceled with less than 24 business hours' notice will be charged a $75 fee, not billable to insurance.
● Arrivals more than 15 minutes late may result in rescheduling.

Other Fees

● Accounts over 90 days past due accrue 1.5% interest per month.
● You are liable for all collection, legal, and court fees.
● $25 fee for returned checks.
● 3% fee for card payments; no fee for cash/check.

Acknowledgment

By signing below, I confirm I understand and accept the terms above. I authorize the release of medical and billing information and assign benefits to Pro Motion Physical Therapy, LLC. I am financially responsible for all unpaid charges.

Patient Name: _____Signature: _____

Date: _____