1 *Client Information*

Last Name	First Name	MI
Address	City	Zip
Date of Birth	☐ Female ☐ Male	Employer (optional)

2 *Contact Information*

Home Phone	Cell Phone	Work Phone (optional)
Email		
Emergency Contact Name	Emergency Contact Phone Number	Relationship to Patient

3 *Health Care Team Information (Optional but recommended)*

Primary Care Physician	Clinic Name/Contact Information
Provider's Name	Clinic Name/Contact Information
Provider's Name	Clinic Name/Contact Information

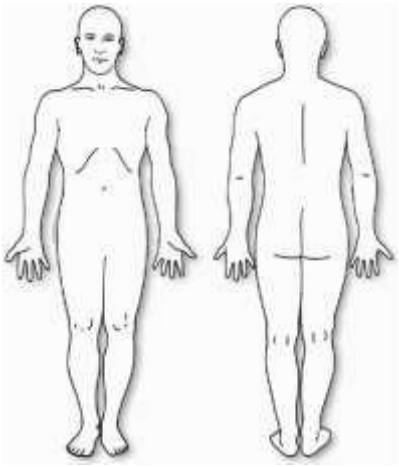
4

How did you hear about Motus Physical Therapy & Performance? (Examples include: Facebook, Twitter, Internet/Web-search, Doctor, Trainer, Massage therapist, Friend, etc.)

x _____ _____

SIGNATURE of Patient/Legal Guardian **Date**

1 *Your current condition*

What is the primary issue that brings you in today?	**Please shade in areas where you have pain or discomfort.** 
Do you have a secondary concern?	
"As a result, I am now having difficulty with":	
Are you currently experiencing pain as a result of these symptoms? If yes, please describe?	
When did your symptom(s) begin?	

Rate your symptoms in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.	At its worst	
	At its best	
	At present	
	While sleeping	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?					
☐ Massage	☐ Bodywork	☐ Physical Therapy	☐ Medications/Injections	☐ Chiropractic	☐ Surgery
Other Medical Treatment: (Please Describe)					

List important activities you are unable or have difficulty performing as a result of your symptoms or pain and indicate your tolerance. If you are no longer able to perform an activity, your tolerance would be "0".	
Activity	Tolerance (minutes/hours)

I walk for		minutes before needing to rest		
I stand for		minutes before needing to sit		
I sit for		minutes before needing to change positions/get up		
Do you have trouble getting up from a chair?			Yes	No
Do you have trouble putting on your shoes and socks?			Yes	No
Do you have difficulty climbing stairs?			Yes	No

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	Yes	No
Is your sleep restful?	Yes	No	How many times do you wake in the night?		
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?		

Do you have any other goals for physical therapy?

2 *Brief Medical History*

Check the box if you have been diagnosed any of the following medical conditions?				
☐Arthritis	☐Broken Bones	☐Circulation Problems	☐Diabetes	☐Epilepsy /Seizures
☐Heart Disease	☐Heart Murmur	☐High Blood Pressure	☐Kidney Disease	☐Liver Disease
☐Lung Disease	☐Malignancy	☐Metal Implants	☐Migraine Headaches	☐Neurological Problems
☐Osteoporosis	☐Pacemaker	☐Pregnancy	☐Rheumatic Fever	☐Stroke
☐Other: (please explain)				

Have you RECENTLY noted any of the following? (check all that apply)		
☐Changes In Bowel Or Bladder Function	☐Fever/Chills/Sweats	☐Weakness/Fatigue
☐Weight Loss/Gain	☐Shortness Of Breath	☐Changes In Appetite
☐Nausea/Vomiting	☐Pain At Night	☐Difficulty Swallowing
☐Dizziness/Lightheadedness	☐Headaches	
☐Other: (please explain)		

List any surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	For treatment of	Dose / Amount per day	Effectiveness

Is there a chance you may be pregnant at this time?	YES NO

List all allergies:				
Are you latex sensitive?	YES NO	Are you sensitive to adhesive bandages?	YES NO	

3 *Lifestyle*

Do you engage in regular exercise?			YES NO	
What type and how often?				
Are you able to exercise now?			YES NO	
Do you have discomfort, shortness of breath, or pain with exercise?			YES NO	
Please Describe:				
In general, your lifestyle is:	1 2 3 4 5			
	Active	Average		Inactive
Do you smoke?	YES NO	If "Yes'-How Much?		

Is there anything else you would like to share regarding your condition, goals, medical history or lifestyle?

I hereby agree that the above information is correct to the best of my knowledge and will inform Motus Physical Therapy & Performance if and when any information changes.

X _____ X _____

Signature of Patient/Legal Guardian **Date**

Consent to Examination and Treatment

Physical therapy is a patient care service that aims to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention through the use of rehabilitative procedures, mobilization, manual therapy, exercises, and more. Physical therapy also aids the patient in achieving their maximum potential within their capabilities and to accelerate and reduce the length of recovery. Physical therapy is provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

Motus Physical Therapy & Performance, PLLC ("Motus") is a hands on clinic. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness. This can last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern; however, please ask if you have any concerns or questions.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

Your response to physical therapy intervention varies from person to person. Therefore, **Motus Physical Therapy & Performance, PLLC does not guarantee what your response will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for**. The number of treatments needed and recovery time can vary due to the age of injury and patient, number of times injured, and many other contributing factors. Furthermore, there is a small possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

Motus is also provides hands-on strength and conditioning services, and may involve placing of hands on the client in a professional manner to guide feedback for better movement or instruct on new techniques. All procedures will be explained to the client prior to performing. There is a small risk that strength and conditioning may cause an increase in symptoms but this should not last for more than 24-48 hours.

By signing below, I do hereby agree and give my consent for Motus Physical Therapy & Performance, PLLC ("Motus") to furnish care and treatment to me or the minor patient listed below that is considered necessary and proper in diagnosing and treating my physical condition, both physical therapy and/or strength and conditioning. This may include, but not limited to exercise, hands on treatment, or use of medical tools and devices whose purpose will be explained prior to use. I understand that Kyle Coffey, PT, DPT of Motus Physical Therapy & Performance, PLLC will take into consideration my/minor patient's conditioning and use his or her best judgment for my/minor patient's safety to help achieve the goals for the treatment. I understand any potential risks, advantages of treatments, and options I have for alternatives. I agree to fully cooperate with and actively participate in all physical therapy procedures, and comply with the established plan of care. I understand that I may stop my request for treatment before any procedure or test.

X _____ **X** _____

Signature of Patient/Legal Guardian **Date**

Financial & Payment Policy

Kyle Coffey, PT, DPT of Motus Physical Therapy & Performance, PLLC is not a preferred provider for insurance companies for physical therapy services. Instead, Motus Physical Therapy & Performance is an out-of-network (OON) provider and a cash-based practice. By not having a preferred provider or contracted status with insurance companies, we do not have to limit the time or quality of the treatment we provide to patients secondary to insurance company restrictions or raise or service rates to pay for billing services.

Prior to your first scheduled physical therapy appointment, call your insurance company to completely understand your physical therapy benefits. *Please refer to the Out-of-Network Insurance Benefits Reference Sheet* to help you ask the insurance company the right questions about your physical therapy benefits. At the time of service and payment, you will receive a written statement which you can submit to your insurance company for their consideration of reimbursement to you. Motus Physical Therapy & Performance, PLLC will be more than happy to provide chart notes or other documentation to help facilitate the process at your request. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse you at 80%, or higher or lower, and some may not reimburse you at all. Motus Physical Therapy & Performance, PLLC cannot make guarantees or estimates regarding what reimbursement your plan allows. By signing below, the patient agrees to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

Medicare and Medicaid patients: Motus Physical Therapy & Performance, PLLC does not accept Medicare or Medicaid and patients cannot be reimbursed for visits.

Injury prevention and strength and conditioning services will not be able to be submitted for insurance reimbursement but may be able to be credited toward a wellness credit if your insurance company offers this. It is your responsibility to check with your insurance company about this potential benefit.

Motus Physical Therapy & Performance, PLLC accepts **cash, check, or credit card at the time of service** for initial evaluation or follow-up visit. Upon completion of the initial evaluation, the therapist will recommend the most appropriate plan of care. All sessions will be one hour in length. The rates are as follows:

Physical Therapy Rates – Thrive Wellness

1. **Initial Evaluation/Treatment or Follow-Up Treatment** (60 minutes): $120
2. **Treatment Package** (6 visits): $630
3. **Post-Op Treatment Package** (12 visits): $1100
4. **Discovery Strategy Session** (30 minutes): $75

Physical Therapy Rates – Mobile Visits

1. **Initial Evaluation/Treatment or Follow-Up Treatment** (60 minutes): $150

Strength and Conditioning Rates – Thrive Wellness

Training packages includes (6) 60-minute training sessions and individual training program

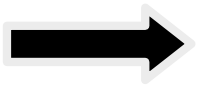
1. **Individual one-on-one training sessions**: $75 for 60 minutes
2. **Training Packages**
    a. **Return to Fitness and Wellness**: $400
    b. **Strength Training for Runners**: $500

Strength and Conditioning Rates – Mobile

1. **Individual training sessions**: $80 for 60 minutes

*** **Patients must prepay for physical therapy and/or strength and conditioning packages to be eligible for package discounts.**

I understand that I am entering into a private payment contract with Motus Physical Therapy & Performance, PLLC (herein as "Motus"). Payment is expected promptly, and at the time service is rendered. I am responsible for all charges, regardless of insurance coverage. I understand that Motus is not a Medicare or Medicaid Provider; therefore, Motus will not submit insurance claims on my behalf, and I cannot submit a self-claim for reimbursement on my own behalf to either Medicaid or Medicare. I can, however, submit self-claims for reimbursement to my commercial insurance company. I understand that Motus still expects prompt payment for all services rendered, regardless of any contract terms I have with my insurance company.



X _____ **X** _____

Signature of Patient/Legal Guardian **Date**

Privacy Statement

I understand that Motus Physical Therapy & Performance, PLLC ("Motus") will maintain my privacy to the highest standards. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. **By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party**, including your private health insurance carrier, Medicare, or Medicaid. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

I understand that I retain the right to revoke consent by notifying Motus Physical Therapy & Performance, PLLC ("Motus") in writing at any time. I verify that I have read and understand the above written policy statements.

X _____ **X** _____

Signature of Patient/Legal Guardian **Date**

Cancellation and No-Show Policy

When you schedule an appointment with Motus, you make a commitment to your health. In turn, we guarantee that time is reserved solely for you. Missed appointments can interfere with your progress in treatment and do not allow the physical therapist an opportunity to offer that time to someone else in need of services. **To ensure that Motus Physical Therapy & Performance, PLLC ("Motus") best meets the needs of all, it is our policy that patients are responsible for all appointments they have scheduled**.

However, we understand that circumstances arise which cause you to cancel your appointment. It is required that all cancellations occur at least 24 hours prior to your schedule appointment time. **If you cancel your appointment less than 24 hours in advance, you will be will pay a cancellation fee of $75 for physical therapy services and $30 for strength and conditioning sessions.** You will be asked to provide a valid credit card when scheduling your first appointment and that credit card will remain on your account indefinitely. In addition, it is the responsibility of the client to be on time for their appointment and the entire fee for the scheduled service will be charged even if the client is late and does not receive the full treatment. This cancellation policy is for all types of appointments. **Extenuating circumstances and special situations will be reviewed on an individual basis per the discretion of Motus Physical Therapy & Performance, PLLC ("Motus").**

I verify that I have read and understand the above written policy statements.

X _____ **X** _____

Signature of Patient/Legal Guardian **Date**

Newsletter Policy

As a client or patient of Motus Physical Therapy & Performance, PLLC, you will be automatically signed up to receive our monthly newsletter using the email provided on the "Patient Information Form". All of your information is kept private and used exclusively for the purposes of keeping you informed of practice news and updates. We promise we will not spam you or flood your inbox with emails. By signing below, I consent to being automatically signed up for the monthly newsletter. **If you wish NOT to be signed up for this newsletter, please initial here: _____**

Multimedia Policy

Photographs or videos may be taken during initial evaluation, progress evaluation, follow-up visits and discharge summary. The primary purpose of the photos or videos is for comparison purposes and as educational tools for you. However, video recordings of treatment techniques and written or video testimonials from our patients help Motus Physical Therapy & Performance get the word out about our services to other potential clients. By signing below, I grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video without payment or any other consideration and consent to the use of these photographs in a professional manner including for advertising and marketing purposes in print or on social media. **If you wish to NOT have any pictures or videos utilized, please initial here:_____**

E-Mail, Voicemail, and Text Communication Policy

I hereby give my consent for the use of email, voice and/or text messaging to communicate about my care at Motus Physical Therapy & Performance, PLLC including pending appointments. I understand that such communications may include personal healthcare information and that such transmissions are not encrypted. Such communications will be limited to Motus Physical Therapy & Performance, PLLC and parties with whom the patient gives written permission to communicate. At no time will Motus Physical Therapy & Performance, PLLC share or publicize contact information. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. **If you wish NOT to be communicated with via email, voicemail, or text, and only by phone, please initial here: _____**

I understand that I retain the right to revoke consent by notifying Motus Physical Therapy & Performance, PLLC (Motus) in writing at any time. I verify that I have read and understand the above written policy statements.

X _____ **X** _____

Signature of Patient/Legal Guardian **Date**

Out-of-Network (OON) Insurance Benefits Reference Sheet

Navigating insurance can be difficult, we will do everything we can to help you with this process. Below is some helpful information. Please understand, this worksheet was created to assist you in obtaining reimbursement for Physical Therapy services and is not a guarantee by Motus Physical Therapy & Performance, PLLC of reimbursement to you.

- **Deductible:** A deductible must be satisfied before the insurance company will pay for therapy treatment. Submit all bills to help reach the deductible amount.
- **Co-Pay**: If you have an office visit co-pay the insurance company will subtract that amount from the percentage they will pay. This will affect the amount of reimbursement you will receive.
- **Reimbursement**: The reimbursement percentage will be based on your insurance company's established "reasonable and customary/fair price" for the service codes rendered. This price will not necessarily match the charges billed; some may be less, some may be more.
- **Referral or Prescription**: If your policy requires a referral or prescription from a provider you must obtain one to send in with the claim. Each time you receive an updated referral you'll need to include it with the claim.
- **Pre-Authorization:** If your policy requires pre-authorization and the insurance company doesn't have one listed yet, you'll need to call the referral coordinator at your provider's office. Ask her to file a referral for your physical therapy treatment that is dated to cover your first physical therapy visit. Be aware that referrals and pre-authorizations have an expiration date and some set a visit limit. If you are approaching the expiration date or visit limit you'll need the referral coordinator to submit a request for more treatment.

Steps to Determine OON Therapy Benefits

1. Call the toll-free number for customer service on your insurance card. Select the option that will allow you to speak with a customer service representative, not an automated system. Let the customer service provider know that you are seeing an **out-of-network (OON) or non-preferred provider**.

2. Ask the customer service representative to quote your ***OUTPATIENT, OUT-OF-NETWORK*** physical therapy benefits. Other terminology for these could be rehabilitation benefits and may include occupational therapy, speech therapy, massage therapy and sometimes chiropractic care.

3. Ask the questions below to obtain the most information possible to guide your decision.

Questions to ask the Customer Service Representative

Name of Representative : _____ Date/time: _____

1. Do I have Out-of-Network Benefits for Outpatient Physical Therapy? Yes No
2. Do I have a deductible? Yes No
   a. If yes, how much is it? _____
   b. How much has already been met? _____
3. Do I have a per calendar year plan or a per benefit year plan?
   a. If per benefit year, what are my dates of coverage? _____
4. What percentage of coverage is my responsibility for seeing an OON or non-preferred provider? _____
5. Does my policy require a written referral or prescription from your primary care physician (PCP)? Yes No
   a. If yes, does it need to come from PCP or will a referral from <u>any</u> MD/physician, nurse practitioner (NP), Physician's Assistant (PA), podiatrist, or a specialist your PCP referred you to be accepted? _____
   b. What is the name of the PCP on file? _____
6. Does my policy require pre-authorization or a referral on file for outpatient physical therapy services? Yes No
   a. If yes, so they have one on file? Yes No
   b. What is the expiration date? _____
   c. Is there a $ or visit limit per year? Yes No
      If yes, what is it? _____
7. Do you require a special form to be filled out to submit a claim? Yes No
8. What is the mailing address where I should send claims and reimbursement forms? _____
9. Is there an online website where I can submit my claim online? If yes, what is it? _____