

PROGRESSIVE MOTION PHYSIOTHERAPY



3475 EDISON WAY, SUITE H, MENLO PARK, CA 94025

Last _____ First _____ Middle Initial _____

Nickname/Preferred Name _____

Parent Name (if under 18) _____

Date of Birth: (MM/DD/YYYY) ____/____/____ Age _____

Driver's License # _____

Phone _____ (is this cell/home/office?) _____

Email _____ Address _____

Your preferred method of contact method: (Phone, Email, Text) _____

What is the earliest ____ and latest ____ time you will accept phone calls?

Is it okay to send personal health information to your email address (Yes/No)?

Is it okay to leave personal health information on your phone voice mail (Yes/No)? _____

Would you like to receive a **SuperBill** for insurance submission(Yes/No)? _____

Please complete all that applies - Employer Name and
City: _____ School Name and City: _____

Sport/Dance Team: _____

Health Information:

Primary Physician: _____ Phone _____

Specialist Physician: _____ Phone _____

In general, how is your overall health over the past year? Excellent, Very Good, Good, Fair, Poor? _____

Please list of all of your medications:

Are you being treated for a work related injury(Yes/No)? _____

Are you being treated for an injury caused by an auto accident (Yes/No)? _____

Is there an attorney for this accident/injury (Yes/No)? _____

Do you practice any type of meditation or breathing Exercises? _____

How many hours or sleep do you average a night? _____

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Please place a checkmark if you have history of any of the following:

Heart Problems	Stroke	Lung issues	Asthma	Seizures	Diabetes
Pacemaker	Hypertension	Blood Clotting disorder	Kidney Disease	Tuberculosis	Thyroid Issues
Cancer	Sudden Weight loss Or gain	Night fever, Chills, sweat	Nausea Or vomiting	Osteoporosis Or osteopenia	Osteoarthritis
Rheumatoid Arthritis	Headaches	Mental Illness	Numbness/ Tingling	Bowel Or bladder Issues	Pelvic pain
HIV/AIDS	hepatitis	Chemical or Alcohol Dependency	Depression	Anxiety	Eating Disorder
Sensitive skin	allergies				

Answer Yes, No, N/A:

Do you smoke _____ Have you started menstruating? _____ Are you pregnant? _____

Do you feel safe at home? _____ Do you feel safe at school? _____

Do you feel safe with your recreational teams/groups? _____

Sign here to indicate that the information provided above is accurate. Additionally, any of the above information or information gathered during physical therapy treatments can be shared with the physicians listed above.

Patient/Client Signature _____ **Date** _____

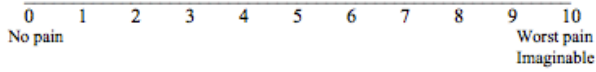
Parent Signature (if under 18) _____ **Date** _____

Print Parent Name _____

By signing here, you have legal rights to make medical decisions for this child



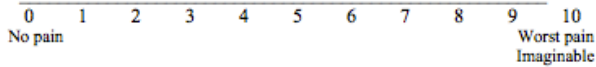
Pain at LOWEST: Rate your lowest pain level in past 24 hrs.



Pain Currently: Rate your level of pain at this time.



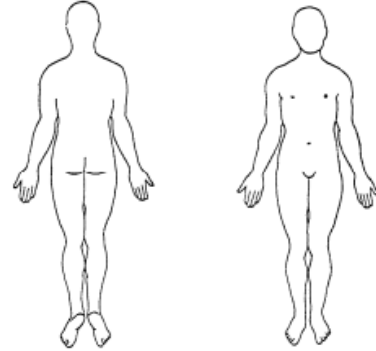
Pain at WORST: Rate your highest pain level in past 24 hrs.



Body Chart:

Please mark the location of your pain and type of pain on the chart:

- Key:
 X sharp stabbing pain
 O Dull achy pain
 ... Numb/Tingling
 /// Throbbing
 == Burning



Please list any other musculoskeletal injuries/surgeries in the past and please include dates: _____

What activities make your current symptoms feel worse? _____

What activities make your current symptoms feel better? _____

What are the goals you would love to achieve for physical therapy? _____

Who is part of your health care team?

- | | | |
|--------------------------------|------------|-----------|
| Do you have a Naturopathic MD? | YES | NO |
| Do you have a dentist? | YES | NO |
| Do you have a psychologist? | YES | NO |
| Do you have a trainer? | YES | NO |
| Do you have a chiropractor? | YES | NO |



**Progressive Motion Physical Therapy -- PATIENT POLICIES effective
07/1/2014 - PLEASE READ AND SIGN AFTER EACH STATEMENT**

Payment Authorization and Patient Responsibility Initial each line:

 Insurance: We do not contract or participate with insurance plans. I hereby authorize Progressive Motion Physical Therapy to furnish my insurance company with any information that may be requested concerning payments of benefits. I understand that I am financially responsible for all charges, whether covered by my insurance or not. I further understand that it is my responsibility to obtain the necessary referrals and/or pre-authorizations from my insurance company.

 MediCare: We are not a contracted Medicare provider. As an unfortunate result, federal law prohibits us from treating MediCare Part B recipients, regardless of payment method. Therefore, by signing this document, you are confirming that you are not a current MediCare Part B recipient.

 Insurance Billing: Upon request, patients will be provided with a copy of their bill at the end of each visit. They may submit the bill to their insurance company for reimbursement.

 Medical Record Copies: Upon written request, patients will be provided a copy of their medical records.

 Appointments: All patients, students, and class participants must have an appointment. You will receive an e-mail once scheduled, but reminder calls will not be made. If you have missed or cancelled an appointment in less than 24 hours you may be charged for the missed appointment.

 Length of appointments: A portion of your appointment time may be used for billing, payments, discussion of home program, scheduling of future appointments, ordering requested equipment, and/or discussion of treatment goals and procedures with patient/client's physician, parent, coach, or teacher.

 Appointment Cancellations: Progressive Motion Physical Therapy asks that patients provide at least 24 hours notice if you cannot keep your appointment. This must be done via text message, email, or preferably online cancellation of your appointment. If you miss your appointment or give less than 24 hours notice you will be asked to pay prior to future appointments.

 Late Arrivals: We ask that you arrive on time for your appointment. Unfortunately, if you are late we are not able to give you your full appointment time, as this would



inconvenience other patients waiting to be seen. Patients will be charged the fee for the entire scheduled appointment regardless of the time the patient arrives.

Release of Liability: In consideration of the services provided by Progressive Motion Physical Therapy, I do hereby agree to release personal representative and estate as follows: I understand and acknowledge that the activity I am about to engage in possesses risks which could result in injury. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in the activity is purely voluntary, no one is forcing me to participate, and I elect to participate in spite of the risks. I hereby voluntarily release, forever discharge and agree to hold harmless and indemnify Progressive Motion Physical Therapy from any and all liability, claims, demands, actions or rights of action, which are related to, arise out of, or are in any way connected to my participation in this activity.

Collaborative Relationship: You have the right to be explained the purpose and benefits of all treatments and exercises. You have a right to terminate treatment at any time. You should communicate any concerns about your treatment

Direct Physical Therapy Treatment Services You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon’s certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist’s plan of care indicating approval of the physical therapist’s plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Patient/Client Signature _____ **Date** _____

Parent Signature (if under 18) _____ **Date** _____

Print Parent Name _____

By signing here, you have legal rights to make medical decisions for this child.



CONSENT TO BE PHOTOGRAPHED

I consent to Progressive Motion Physiotherapy, to photograph or permit other persons to photograph, record, conduct media interviews, publish and/or post website information/social media, statements or images during sessions.

I consent to the taking and use of photographs, recordings and interviews of me, and to the publications of such photographs, interviews, and to the publication of information, statements or images of or about me, including without limiting posting on websites/social media, in order to assist scientific treatment, educational, promotional, public relations and charitable goals. By signing this authorization and consent form, I hereby waive any right to compensation for such uses, and I and my successors or assigns hereby hold Progressive Motion Physiotherapy its administrators, agents, and related entities, harmless from and against any claim for any injury, and any compensation, resulting from the activities authorized by me in this consent form.

The term “photograph” as used in foregoing agreement shall mean motion picture or still photography in any format, as well as videotape, videodisc, website, and any other mechanical means of recording and reproducing images.

I hereby waive my right under relevant state laws to patient confidentiality with respect to the taking or publishing of any photograph, record, interview, statement or image of me, as authorized in this consent form, with the exception of those limitations specifically identified by me in this consent form. I understand that I have the right to revoke this waiver, and to revoke my consent and authorization in this form, at any time, by notifying Progressive Motion Physiotherapy in writing, as discussed herein.

By signing below, I acknowledge that I have read and understood the above and agree to the terms of this consent.

Signature: _____

Printed Name: _____ **Date:** _____

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