In Motion Therapy

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

PATIENT INFORMATION

Date _____

Patient Name: First_____ Middle Initial_____ Last_____

Date of Birth_____ Age_____ Sex_____ Marital Status_____

Social Security #_____ Height_____ Weight_____

Address_____City_____State_____ Zip_____

Primary Phone_____ Appointment Reminder: **Text?** ☐ **Call?** ☐

Secondary Phone Number_____

Email Address_____

Emergency Contact Name_____ Phone#_____ Relationship_____

Employer_____ Emp Phone #_____

Referring Physician_____ Office Phone #_____

How did you hear about us? _____

Is this accident Work ☐ Auto ☐ Home ☐ Other _____ Lawyer Involved? Yes / No

Work Comp Claim #_____ Work Comp Insurance_____

INSURANCE INFORMATION

Are you covered by Colorado Medicaid? _____ **Are you applying for Colorado Medicaid?** _____

Primary Insurance_____ Member ID _____Group #_____

Policy Holder Name_____ Date of Birth _____

Secondary Insurance_____ Member ID_____ Group #_____

Policy Holder Name_____ Date of Birth _____

RESPONSIBLE PARTY INFORMATION (if other than patient)

Responsible Party First Name_____ Middle Initial_____ Last_____

Date of Birth_____ Relationship to Patient_____

Signature of Responsible Party_____ Date_____

Signature of Patient_____**Date**_____

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Name: _____ **Date:** _____

What body part are you being seen for today? _____ Circle one: Right Left Both

When and ***how*** did your problem start? (If specific date is unknown, please estimate time of year)

_____

Did you have surgery for this problem? _____ Date of Surgery: _____

Pertaining to this problem you are being seen for today, have you had any:

X-Ray Date:_____ Location:_____ **MRI** Date:_____ Location:_____

CT Date:_____ Location:_____ **EMG** Date:_____ Location:_____

Other:_____

Please rate your pain on a scale of **0** (no pain) to **10** (unbearable):

At Worst_____/10 Current_____/10 At Best _____/10

Describe your pain (please circle ***one*** that most applies):

burning sharp dull/ achy throbbing shooting numbness/tingling

constant intermittent worse in morning worse in evening

What makes your pain worse? _____

What makes your pain better? _____

Are any of your daily activities affected? If so, how? _____

What are your **goals** for therapy? _____

MEDICAL HISTORY Please circle all that applies to you:

Alzheimer's	Cancer Type: Year:	Traumatic brain injury Type: Year:	Fracture/Expected Fracture
Cardiovascular Disease Type: Year:	Huntington's Disease	Immunosuppression	Unexplained Weight Loss
Stroke/TIA Type: Year:	Lupus	Blood Clots	Parkinson's Disease
Current Infection Type:	Multiple Sclerosis	Dizziness	Obesity
Diabetes Type:	Muscular Dystrophy	Falls	Pacemaker
Fibromyalgia	Rheumatoid Arthritis	Headaches	Osteoporosis
High Blood Pressure	Osteoarthritis	Mental Health Illness Type:	Do You Smoke:

Please list or attach current medications and/or supplements: _____

_____

Do you have any allergies? _____

Have you had any physical or occupational therapy this year? _____

Are you receiving or have you received home health care of any kind this year? _____

DO YOU HAVE A PACEMAKER? _____

I hereby consent to the evaluation and treatment of my condition by a licensed therapy provider employed by In Motion Therapy.

Patient Signature: _____ Date: _____

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Appointment Cancellation / No Show Policy

At In Motion Therapy, we believe that each patient is entitled to their therapist's full attention during their appointments. To help achieve this, our office offers the option of voice call or text reminders the day before each appointment to remind of appointment time.

If you wish to cancel your appointment, we ask that this be done 24 hours in advance. If you cannot do so during normal office hours, (8-6 Monday through Thursday, 8-5 Friday), then please call and leave a message on our voicemail.

If any new patient or preexisting patient fails to appear or cancel an appointment without 24-hour notification, a $25.00 fee will be applied to your account and due at your next appointment. With reasonable consideration of circumstances, (unforeseen emergencies, sickness or weather-related delays), we will handle each instance on a case-by-case basis. The above charge is not covered by any insurance plan; therefore, you will be personally responsible for this fee before any further appointments can be scheduled.

My signature below indicates that I understand and will abide by this policy.

_____ _____

Signature of Patient/ Guardian **Date**

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Payment & Privacy Consent

I have read, and agree to all information included and described in the In Motion Therapy Notice of Privacy Practices.

I hereby authorize payment of medical benefits billed to my insurance by In Motion Therapy. I have listed all health insurance plans from which I may receive benefits.

You are responsible for supplying your own personal insurance, or work comp/ auto information to our office. If you do not give us your accurate information you will be responsible for all charges incurred and payment will be expected at the time of service. Please present all insurance cards to be scanned.

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time of services. I understand that any unpaid balances will be my responsibility.

Patient Signature_____ **Date**_____