# LifeMotion Physical Therapy
## MEDICAL HISTORY AND CURRENT COMPLAINTS

*Please answer all questions to the best of your ability.*

Your Name: _____ Today's Date: _____/_____/_____

Age: _____ Height: _____ Weight: _____ Hand Dominance: R / L

What problem(s) are you being treated for today? _____

What date did your present symptoms start? _____

My symptoms are currently: **GETTING BETTER** **GETTING WORSE** **STAYING THE SAME**

Treatment received so far for this problem: (circle) **Physical / Occupational Therapy** **Chiropractic**

**Acupuncture** **Injections** **Other:** _____

Have you received physical / occupational therapy within the last calendar year? **YES** **NO**
Approximately how many treatment sessions have you received this calendar year? _____

Special tests performed for this problem and results (circle): **X-ray** **Bone Scan** **CT Scan** **MRI**

**Other:**_____

Activities required for your occupation (circle): **Sitting** **Standing** **Walking** **Lifting** **Reaching**

**Other:** _____

Are you on a work restriction from your doctor: **Light Duty** **Full Duty** **Not Working** **N/A**

LEISURE ACTIVITIES (include exercise routines): _____

_____

ALLERGIES: List any medication(s) you are allergic to: _____

_____

Is there anything else we should know that is pertinent to your treatment? _____

_____

What is your goal(s) for therapy? What do you want to get back to doing? _____

_____

_____

_____

3345 S. Harvard Ave., Suite 101/301 Tulsa, OK 74135
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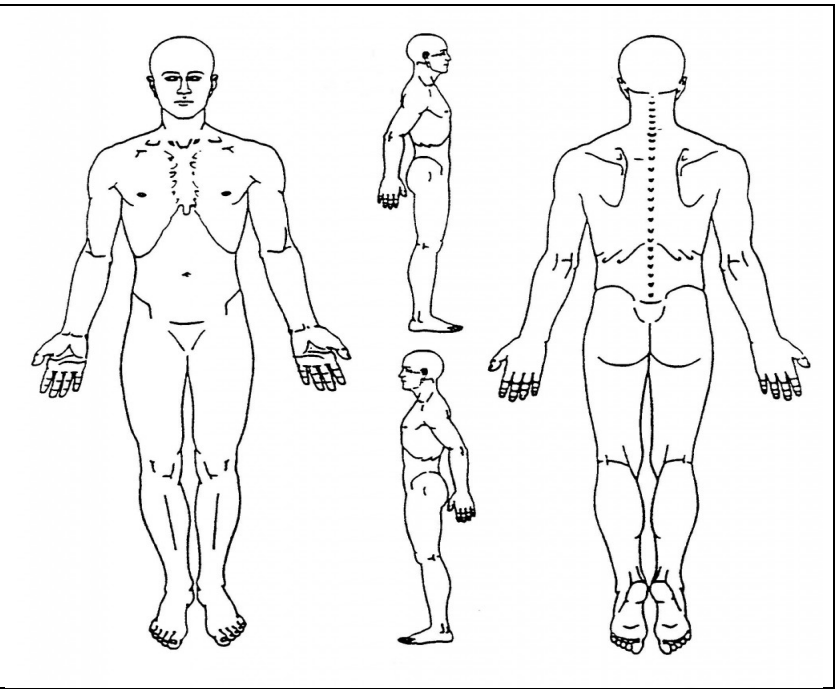
**BODY CHART**

| | |
|---|---|
| Please mark the areas where you feel symptoms on the chart with the following symbols to describe your symptoms:<br><br>↓ Shooting / sharp pain<br><br>X Dull / aching pain<br><br>0 Numbness |  |

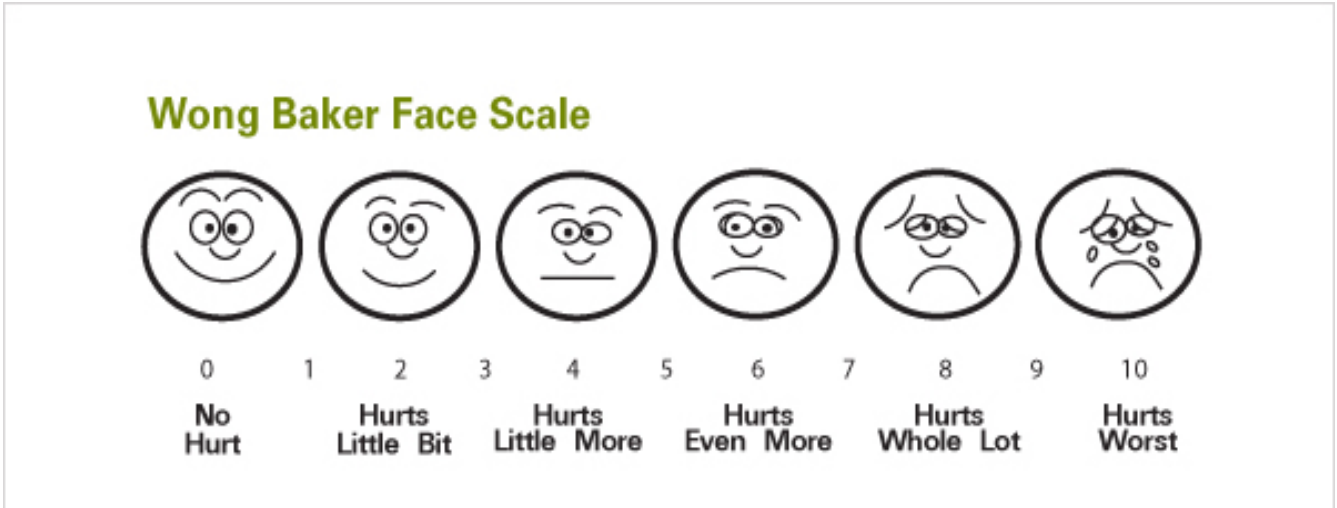
How would you describe your current symptoms (circle as many as apply): **Sharp** **Burning** **Dull** **Throbbing** **Shooting** **Aching** **Cramping** **Crushing** **Stabbing** **Tingling** **Coldness** **Hotness** **Electricity** **Stiffness** **Dizziness** **Other:** _____

My symptoms: **COME AND GO** **ARE CONSTANT** **CONSTANT, CHANGE WITH ACTIVITY**

What makes your symptoms *better*: _____

What makes your symptoms *worse*: _____

Circle a number below that best describes your current pain levels:



# LifeMotion Physical Therapy

## MEDICAL HISTORY

### CURRENT OR PREVIOUS CONDITIONS *(mark all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| Allergies | ◯ Yes ◯ No | Dizzy Spells | ◯ Yes ◯ No | MRSA | ◯ Yes ◯ No |
| Anemia | ◯ Yes ◯ No | Emphysema/Bronchitis | ◯ Yes ◯ No | Multiple Sclerosis | ◯ Yes ◯ No |
| Anxiety | ◯ Yes ◯ No | Fibromyalgia | ◯ Yes ◯ No | Muscular Disease | ◯ Yes ◯ No |
| Arthritis | ◯ Yes ◯ No | Fractures | ◯ Yes ◯ No | Osteoporosis | ◯ Yes ◯ No |
| Asthma | ◯ Yes ◯ No | Gallbladder Problems | ◯ Yes ◯ No | Parkinson's | ◯ Yes ◯ No |
| Autoimmune Disorder | ◯ Yes ◯ No | Headaches | ◯ Yes ◯ No | Rheumatoid Arthritis | ◯ Yes ◯ No |
| Cancer | ◯ Yes ◯ No | Hearing Impairment | ◯ Yes ◯ No | Seizures | ◯ Yes ◯ No |
| Cardiac Conditions | ◯ Yes ◯ No | Hepatitis | ◯ Yes ◯ No | Smoking | ◯ Yes ◯ No |
| Cardiac Pacemaker | ◯ Yes ◯ No | High / Low Blood Pressure | ◯ Yes ◯ No | Speech Problems | ◯ Yes ◯ No |
| Chemical Dependency | ◯ Yes ◯ No | High Cholesterol | ◯ Yes ◯ No | Strokes | ◯ Yes ◯ No |
| Circulation Problems | ◯ Yes ◯ No | HIV / AIDS | ◯ Yes ◯ No | Thyroid Disease | ◯ Yes ◯ No |
| Currently Pregnant | ◯ Yes ◯ No | Incontinence | ◯ Yes ◯ No | Tuberculosis | ◯ Yes ◯ No |
| Depression | ◯ Yes ◯ No | Kidney Problems | ◯ Yes ◯ No | Vision Problems | ◯ Yes ◯ No |
| Diabetes | ◯ Yes ◯ No | Metal Implants | ◯ Yes ◯ No | | |

### DESCRIBE

If "Yes" to ANY of the above, please explain and give approximate dates. Describe and list any other conditions.

### FALL HISTORY (please circle)

Injury as a result of a fall in the past year? **YES** **NO**
Two or more falls in the last year? **YES** **NO**
Are you at risk for falls? **YES** **NO**

### SURGICAL HISTORY

Body Region: _____ Surgery Type: _____ Date: ____/_____/_____
Body Region: _____ Surgery Type: _____ Date: ____/_____/_____
Body Region: _____ Surgery Type: _____ Date: ____/_____/_____
Body Region: _____ Surgery Type: _____ Date: ____/_____/_____
Body Region: _____ Surgery Type: _____ Date: ____/_____/_____

### CURRENT MEDICATIONS

*If not currently taking any meds, please check this box.* ☐

Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____

# LifeMotion Physical Therapy

## REGISTRATION

Date: _____/_____/_____ Clinic Location (circle): Ortho/Pelvic Center Balance Center

Name: _____
(First) (Last) (Middle)

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____)_____ HOME / CELL / WORK (circle)

Alternate Phone: (_____)_____ HOME / CELL / WORK (circle)

Birth Date: ____/____/_____ SSN: ____-____-_____ Email: _____

Marital Status (circle): Married Single Other Sex (circle): Male Female

Former Client (circle): YES NO

How did you hear about LifeMotion Physical Therapy (circle)?

Friend Website Physician Golf Seminar Insurance Staff Advertisement Other

If a category was circled above, please specify name / organization: _____

**CURRENT EMPLOYMENT INFORMATION**

Employer: _____ Occupation: _____

Address: _____ Bus. Phone: _____

**EMERGENCY CONTACT INFORMATION**

Contact: _____ Phone Number: _____Relationship: _____

**PHYSICIAN INFORMATION**

Referring Physician: _____ Phone: (_____)_____

Address: _____

If you would like us to send copies of clinical updates to your primary care physician, please complete:

Primary Care Physician: _____ Phone: (_____)_____

Address: _____ Fax: (_____)_____

# LifeMotion Physical Therapy
# PAYMENT INFORMATION

**HOW DO YOU PLAN TO PAY FOR SERVICES RENDERED TO YOU? (circle)**

CASH INSURANCE AUTO / 3rd Party WORKER'S COMP

**INSURANCE INFORMATION (if applicable)**

*Please provide your insurance card and driver's license so that we may make a copy for your records.*

Primary Insurance Company: _____

Name of Policy Holder: _____ Relationship: _____

Date of Birth: _____/_____/_____ ID #: _____ Group #: _____

Secondary Insurance Company: _____

Name of Policy Holder: _____ Relationship: _____

Date of Birth: _____/_____/_____ ID #: _____ Group #: _____

**Have you verified your therapy benefits with your insurance?: (circle) YES NO**

***If not, we strongly encourage you to do so. You are responsible for payment in full.***

**AUTO / 3RD PARTY AUTO INFORMATION (if applicable)**

Is this an auto accident? (circle) YES NO Date of Accident: _____/_____/_____

Is this a lawsuit? (circle) YES NO Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____

**WORKERS COMPENSATION (if applicable)**

Employer's Name: _____ Employer's Phone: (_____)_____

Job Title: _____

Is than an approved Worker's Comp Injury? (circle) YES NO Date of Injury: _____/_____/_____

Law Firm Name: _____ Attorney Name: _____

Attorney Phone: (_____)_____

Adjuster Name: _____ Adjuster Phone: (_____)_____

## Consent for Treatment

I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and considered necessary or advisable by my physician(s) and therapist. I acknowledge that no guarantees have been made to me about the results of treatment.

I give permission for my physical therapist and their support staff to treat me in an open room where others are also being treated. I am aware that other persons in the clinic may overhear some of my protected health information during the course of my care and conversation with me. Should I need to speak to my physical therapist or support staff at any time in private, a private room for these conversations will be provided to me.

**Client Signature: _____ Date: _____/_____/_____**

## Authorization to Communicate

I give permission to LifeMotion Physical Therapy to contact me by phone, email, or text with appointment reminders, including leaving messages at home or work. I give permission to LifeMotion to contact me with birthday cards, holiday related cards, and information about treatment alternatives or other health related information, including a practice newsletter. I give permission to receive thank you messages for referrals. I give permission to request a review of our services by email or text.

**Client Signature: _____ Date: _____/_____/_____**

## No Show / Cancellation Policy

**We charge a $50 fee for no shows and appointments cancelled with less than 24 hours notice. We will kindly waive the fee if you can make the appointment up within one business day of the original appointment.**

Yes, we charge you for not showing up for your appointment or canceling with less than 24 hours notice just like a hotel or airline does. Why? We reserved the spot for you on your word that you would be here. If you don't show up or cancel too late, of course that hurts you because you don't get what you need, but it also hurts us. We won't have adequate time to fill the appointment. So, please call us if you can't make your appointment at least 24 hours ahead of time.

I have read and understand LifeMotion's No Show / Cancellation Policy.

**Client Signature: _____ Date: _____/_____/_____**

# LifeMotion Physical Therapy
## Statement of Financial Responsibility and Privacy Notice

1. **RESPONSIBILITY FOR PAYMENT.** I acknowledge that in consideration of the services provided to me by LifeMotion, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide LifeMotion with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance or other programs for which I am eligible.

    - *As a service to you, we will submit claims to your primary insurance correctly <u>one</u> time. You are responsible for payment of the services and products rendered to you.* ***<u>If your insurance has not paid LifeMotion in full within 45 days of the date of services rendered, you are responsible for the bill and for attempting to reimburse yourself.</u>*** *We expect payment from you within 15 days of you receiving a statement from LifeMotion.*
    - *Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Insurance claims are filed as a courtesy to you. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-pays, co-insurance, and/or coverage disputes other than to supply factual information as necessary. You are responsible for the timely payment of your account.*
    - *Any charges not covered by your insurance company due to medical necessity, policy limitations, policy maximums, modality maximums, usual and customary guidelines and/or the difference between benefits verified and the benefits paid are your responsibility.*
    - *We do not file claims for Medicaid or SoonerCare.*
    - *We will, in certain situations, accept third party injury cases after review of the facts of your case. It is your responsibility to provide all pertinent information. LifeMotion will file a third party lien until your account is paid in full.*

***Please note that refusal to sign this form does not change responsibility for payment in any way.***

2. **ASSIGNMENT OF BENEFITS.** I hereby assign LifeMotion all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

3. **ACCESS TO AND RELEASE OF HEALTH INFORMATION.** I understand that LifeMotion may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and LifeMotion's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment, including imaging and operative reports. I acknowledge that I have received LifeMotion's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information. I understand I can revoke this authorization at any time but submitting a request to the Privacy Officer.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this Statement Financial Responsibility and Privacy Notice and sign below freely and voluntarily.

_____ _____/_____/_____

Signature of Client or Legally Responsible Person Date

_____

Printed Name

3345 S. Harvard Ave., Suite 101/301 Tulsa, OK 74135
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# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## Uses and Disclosures

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Your confidential medical information is defined under federal law as "protected health information" ("PHI"). When we retain your confidential medical information on its computer system, it is called "electronic protected health information" ("ePHI"). This Notice applies to all PHI and ePHI related to your care that we have created or received. It also applies to any personal or general information we receive from patients, including information contained on driver's licenses. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

### USE AND DISCLOSURE WITHOUT PATIENT ACKNOWLEDGEMENT OF THIS NOTICE

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

**Treatment:** We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

**Payment:** We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

**Operations:** Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

### USE AND DISCLOSURE WITHOUT ACKNOWLEDGEMENT OR AUTHORIZATION

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

### AUTHORIZATION FOR USE OR DISCLOSURE

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records without your specific written consent and authorization. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization. Your medical information will not be disclosed for marketing purposes or sold to any third party without your authorization.

Other uses and disclosures of your medical record information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to "take back" any disclosures that we have already made with your permission and that we are required to keep any records of the care that we provided to you.

**Additional Uses and Disclosures**

**Advice of Appointment and Services:** The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you. The following appointment reminders may be used by the Practice: a) postcard mailed to you at your address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

**Individual Rights**

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services out of your own pocket, in full. This does not apply to services that are covered by insurance. You are required to pay cash, in full, for the services before the restriction applies.

3. With respect to ePHI, we agree to give you your ePHI in the form and format requested by you, if it is readily producible in that form or format. If it is not readily producible in the form or format requested, we will give you a readable hard copy form. Any directive given to us by you to transmit ePHI must be done in writing by you, signed and clearly identify the designated person and location to send the ePHI. We will provide you access to your PHI or ePHI within thirty (30) days from the date of request.

4. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

5. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

6. We may deny any request for amendment of your PHI or ePHI if the information was not created by us (unless the originator of the information is no longer available to act on your request); is not part of the designated record set maintained by us; is not part of the information to which you have a right of access; or is already accurate and complete, as determined by us. If we deny your request for an amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

7. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.

8. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

9. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.

10. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

11. You have the right to receive notification from us if any breach of your unsecured protected health information occurs.

**Our Duties**

*We have the following duties with respect to the maintenance, use and disclosure of your medical records:*

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

**Complaints**

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: http://www.hhs.gov/ocr/hipaa.

**This Notice of Privacy Practices shall not be construed as a contract or legally binding agreement. Any non-compliance with any provision of this Notice shall not be construed as a breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law. By signing the Acknowledgment of Receipt of this Notice, you agree that the sole legal recourse for our non-compliance with this Notice is to file a written complaint to the Secretary of the U.S. Department of Health and Human Services, and that no complaint or cause of action may be filed in any federal or state court for breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law, or under any tort theory.**

**Contact Person**

All questions concerning this Notice, or requests made pursuant to it, should be addressed to:

Ryan Smith, Privacy Officer
At the following address: 3345 S. Harvard Ave, Suite 101, Tulsa OK 74135
E-mail: rsmith@yourlifemotion.com

**Effective Date**

This Notice is effective **April 14, 2003 and revised September 23, 2013** and applies to all protected health information contained in your medical records maintained by us.

# CONCUSSION ADDENDUM

1. When did your concussion occur? _____
2. What part of your head did you hit? _____
3. Did you lose consciousness? **YES** **NO**
4. Do you remember the moment your concussion occurred? **YES** **NO**
5. Do you remember the events before your concussion? **YES** **NO**
6. Do you remember the events after your concussion? **YES** **NO**
7. What were your immediate symptoms after your concussion? (circle all that apply)

| | |
|---|---|
| **Headache** | **Sensitivity to noise** |
| **"Pressure in head"** | **Feeling slowed down** |
| **Neck Pain** | **Feeling like "in a fog"** |
| **Nausea** | **"Don't feel right"** |
| **Vomiting** | **Difficulty concentrating** |
| **Dizziness** | **Difficulty remembering** |
| **Blurred vision** | **Fatigue or low energy** |
| **Balance Problems** | **Confusion** |
| **Sensitivity to light** | **Drowiness** |

8. Did you have an MRI, CT Scan, or X-rays? **YES** **NO**
   a. If so, results: _____
9. What were your symptoms 48 hours after your concussion? (circle all that apply)

| | |
|---|---|
| **Headache** | **Sensitivity to noise** |
| **"Pressure in head"** | **Feeling slowed down** |
| **Neck Pain** | **Feeling like "in a fog"** |
| **Nausea** | **"Don't feel right"** |
| **Vomiting** | **Difficulty concentrating** |
| **Dizziness** | **Difficulty remembering** |
| **Blurred vision** | **Fatigue or low energy** |
| **Balance Problems** | **Confusion** |
| **Sensitivity to light** | **Drowiness** |

10. Have you had any previous concussions? **YES** **NO**
    a. If yes, how many? _____
11. Is there anything else your physical therapist needs to know? _____

_____

_____

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