



# CLIENT DEMOGRAPHIC

## DEMOGRAPHICS

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell Number \_\_\_\_\_ Alt. Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Social Security Number \_\_\_\_\_ Email Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## EMPLOYMENT INFORMATION

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

## INSURANCE INFORMATION

Person Responsible for Payment (Subscriber) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (If Different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Cell Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Name of Insurance Provider \_\_\_\_\_ ID Number (As Appears on Card) \_\_\_\_\_

Group Number \_\_\_\_\_

## EMERGENCY CONTACT INFO

Name of Contact \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Cell Number \_\_\_\_\_ Home Number \_\_\_\_\_

**The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the Mobility Fit Physical Therapy, LLC. I understand that I am financially responsible for any balance. I authorize MOBILITY FIT PHYSICAL THERAPY LLC or insurance company to release any information required to process my claims.**

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



# MEDICAL QUESTIONNAIRE

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe the injury/problem that brings you to Mobility Fit Physical Therapy. How did the injury occur?

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Side of injury/problem LEFT or RIGHT

Approximate date of injury/onset of problem: \_\_\_\_\_

Rate your pain on a scale from 1 (best) to 10 (worst) from the past 48 hours:

Best: \_\_\_\_\_ Worst: \_\_\_\_\_ Current: \_\_\_\_\_

What activities/specific exercises are you unable to perform

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Describe your symptoms. What *eases* them and what *aggravates* them?

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Have you previously received treatment for this problem (PT, Chiropractic, etc)?

YES or NO

If YES, please explain all the treatment you have received:

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Have you had any tests for this problem? (Circle all that apply)

MRI CT Scan X-RAY Other: \_\_\_\_\_

What are your goals for Physical Therapy?

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# MEDICAL QUESTIONNAIRE

Please list all surgeries or illnesses for which you have been hospitalized or treated, including approximate date.

DATE: \_\_\_\_\_ SURGERY/TREATMENT \_\_\_\_\_ REASON \_\_\_\_\_

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## MEDICAL HISTORY (Please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Angina/Chest Pain         | <input type="checkbox"/> Migraine/Headaches                | <input type="checkbox"/> Arterial Calcification  |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Major Spinal Injury               | <input type="checkbox"/> Kidney Conditions   |
| <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> MRSA                              | <input type="checkbox"/> Blood Clotting Issues: Factor V Leiden, Venous Thromboembolism, etc |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Nicotine Use/Alcohol Consumption  | <input type="checkbox"/> Extremities with Dialysis Access                                    |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Osteoporosis                      | <input type="checkbox"/> Acidosis  |
| <input type="checkbox"/> Carpel Tunnel Syndrome    | <input type="checkbox"/> Pacemaker/Nitroglycerin           | <input type="checkbox"/> Sickle Cell Anemia/Trait  |
| <input type="checkbox"/> Chest/Abdominal Surgery   | <input type="checkbox"/> Poor Circulation/Raynaud's        | <input type="checkbox"/> Extremity Infection   |
| <input type="checkbox"/> Coronary Artery Disease   | <input type="checkbox"/> Seizures                          | <input type="checkbox"/> Tumor of Arm or Leg   |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Traumatic Brain Injury/Concussion | <input type="checkbox"/> Increased Intracranial Pressure                                     |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Motor Vehicle Accident            | <input type="checkbox"/> Medications/Supplements known to increase the risk of clotting      |
| <input type="checkbox"/> Type 2 Diabetes           | <input type="checkbox"/> Fractures                         | <input type="checkbox"/> Severe Crushing Injuries  |
| <input type="checkbox"/> Type 1 Diabetes           | _____  | <input type="checkbox"/> Vascular Surgery: Grafting, Revascularization, etc                  |
| <input type="checkbox"/> Endometriosis             | _____  | <input type="checkbox"/> Lymphectomies/Lymphatic Dysfunction                                 |
| <input type="checkbox"/> Fibromyalgia              | _____  |  |
| <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Other                             |  |
| <input type="checkbox"/> Hepatitis                 | _____  |  |
| <input type="checkbox"/> High Blood Pressure       | _____  |  |
| <input type="checkbox"/> High Cholesterol          | _____  |  |
| <input type="checkbox"/> Hypoglycemia              | _____  |  |
| <input type="checkbox"/> Low Blood Pressure        | _____  |  |

CURRENT MEDICATIONS |PURPOSE | DOSAGE

CURRENT MEDICATIONS |PURPOSE | DOSAGE

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# CLIENT CONSENT FORM

1. I, the Client, or parent/guardian of the client, \_\_\_\_\_, do hereby voluntarily consent to such care encompassing evaluation procedures and medical treatments sought by myself and/or as ordered by a physical therapist from Mobility Fit Physical Therapy.
2. I authorize the staff of Mobility Fit Physical Therapy to undertake such procedures and treatments as deemed appropriate to improve my condition.
3. It is recognized that the at-home program I am given by Mobility Fit Physical Therapy is a necessary component to the improvement of my condition, and therefore my responsibility to carry out in order to make these improvements in a timely manner.
4. I authorize that I am responsible for understanding my contract with my insurance provider and that I may be contacted by an employee of Mobility Fit Physical Therapy to discuss my Physical Therapy coverage.
5. I hereby authorize Mobility Fit Physical Therapy to release medical information regarding myself and my current condition to my insurance company, as well as referring, consulting, treating physicians or other medical providers as needed to support continuity of care.
6. I understand that I have the right to a full explanation of treatments and procedures. I understand that I have the right to refuse any treatment; but, in doing so, I also understand that the desired outcome of my treatment plan may be negatively affected.
7. I consent to the use of still photography and/or video analysis as a component of my physical therapy services. These will be used as necessary for my plan of care, and I will be made aware when these photos or videos are being taken. I understand that these photo's and/or videos are an important component of monitoring my progress and treatment.

*Please Initial* \_\_\_\_\_

8. I give my permission to use any pictures and/or videos taken for purposes including but not limited to social media postings, publications, advertisements, educational material, or in any medium now known or later developed, including the internet.

\_\_\_\_\_ *I DO give my consent to Mobility Fit Physical Therapy to use my name and likeness to promote the above mentioned. (Line 8)*  
Initial

\_\_\_\_\_ *I DO NOT give my consent to Mobility Fit Physical Therapy to use my name and likeness to promote the above mentioned. (Line 8)*  
Initial

9. I have fully read the above in its entirety and I fully understand and agree to its contents.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Signature of Client

Date \_\_\_\_/\_\_\_\_/\_\_\_\_



# CLIENT PAYMENT AGREEMENT

Mobility Fit Physical Therapy strives to provide you with a clear understanding of your financial responsibility with respect to the medical services we provide. Please read our policies below and provide your signatures.

We will gladly contact your insurance company to obtain your current benefit coverage. However, that information can be used only as a guideline and does not guarantee medical benefits or payment.

\_\_\_\_\_ I understand that it is ultimately my responsibility to know and understand my benefit coverage  
*Initial* for Physical Therapy.

\_\_\_\_\_ I understand that my insurance company will determine and pay for services according to my  
*Initial* plan benefits

\_\_\_\_\_ I understand it is my responsibility, and agree to; pay all co-pays, co-insurance, or deductibles  
*Initial* at the time of service.

\_\_\_\_\_ I understand that it is my responsibility to pay all balances for uncovered services within 30  
*Initial* days of my discharge from PT.

\_\_\_\_\_ I authorize Mobility Fit Physical Therapy to release my medical information to insurance  
*Initial* companies, medical billing employees, physicians, and all other parties that may be involved in my claim

\_\_\_\_\_ I understand that there will be a \$20 fee automatically charged to my account per bounced check.  
*Initial*

I wish to accept the insurance submission option, thus allowing Mobility Fit PT to send all claims to the insurance company provided for processing.

\_\_\_\_\_  
Client Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

I have fully read, understand, and agree to the above Mobility Fit PT payment requirements. I authorize Mobility Fit PT to release pertinent medical information related to my insurance.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client Signature (or responsible party if minor)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



## CANCELLATION AND NO-SHOW POLICY

Our goal is to provide a physical therapy experience far superior to any you have previously known or experienced. This means that you will be scheduling one-on-one sessions with one of our doctors of physical therapy. Each and every appointment space is important; therefore our no-show and late cancellation policies are in place in order to maximize the available offerings for our clients.

**EFFECTIVE JULY 1, 2018**

### ***Cancellation Policy & No-Show Policy:***

With the high demand for available slots, we require 24-hours advanced notice to cancel an appointment.

- Cancellations or a no-show with less than 24-hours notice will receive a charge to their account, as follows:
  - **\$50 per appointment**
  - **Multiple late cancellations or no-shows may result in termination from therapy at Mobility Fit's discretion.**

### ***Late Arrival Policy:***

We value each and every one of our clients and we desire for everyone to receive the same high-level of care at each and every visit.

- **In order to ensure this high-level of care, should you arrive 15 minutes or later from your scheduled start time, we will need to reschedule that appointment for another day and a late cancellation fee may apply. Our Client Coordinators will reach out to you after 10 minutes to determine how to proceed.**

By signing below, I understand that should I no-show, late cancel, or arrive late my account will either be charged or payment will be collected at my next visit. I understand that this policy is to encourage my dedication to the process and to ensure success for all.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_