MOBILITY FIT
PHYSICAL THERAPY

CLIENT DEMOGRAPHICS

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____/____/____

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MEDICAL QUESTIONNAIRE

Name_____ Today's Date____/____/____

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

_____

_____

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

_____

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

_____

_____

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

YES or NO | If YES, how many visits completed in this calendar year? _____

If YES, please explain all treatments you have received:

_____

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

_____

_____

MEDICAL HISTORY (Please check all that apply)

- ☐ Angina/Chest Pain
- ☐ Asthma
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Bowel or Bladder Problems
- ☐ Carpel Tunnel Syndrome
- ☐ Chest/Abdominal Surgery
- ☐ Coronary Artery Disease
- ☐ Cancer
- ☐ Depression
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Migraine/Headaches
- ☐ Major Spinal Injury
- ☐ MRSA
- ☐ Nicotine Use/Alcohol Consumption
- ☐ Osteoporosis
- ☐ Pacemaker/Nitroglycerin
- ☐ Poor Circulation/Raynaud's
- ☐ Seizures
- ☐ Traumatic Brain Injury/ Concussion
- ☐ Motor Vehicle Accident
- ☐ Fractures

  _____

  _____

  _____
- ☐ Other

  _____

  _____

  _____
- ☐ Arterial Calcification
- ☐ Kidney Conditions
- ☐ Blood Clotting Issues: Factor V Leiden, Venous Thromboembolism, etc
- ☐ Extremities with Dialysis Access
- ☐ Acidosis
- ☐ Sickle Cell Anemia/Trait
- ☐ Extremity Infection
- ☐ Tumor of Arm or Leg
- ☐ Increased Intracranial Pressure
- ☐ Medications/Supplements known to increase the risk of clotting
- ☐ Severe Crushing Injuries
- ☐ Vascular Surgery: Grafting, Revascularization, etc
- ☐ Lymphectomies/Lymphatic Dysfunction

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____/____/____

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NOTIFY MY DOCTOR (optional)

Would you like your evaluation notes to be sent to your referring provider or primary care doctor?

☐ If NO, please check the box to opt out

If YES, please provide your referring provider/primary care doctor's contact information:

Doctor's Name_____Office Phone (____)_____-_____

Practice Name_____Clinic Location_____
(city)

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PHYSICAL THERAPY

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.

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

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

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

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

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

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

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

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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 is 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: ____/____/____