



149 Raymond Hirsch Pkwy • Suite 1 • PO Box 9 • White House, TN 37188

Phone: (615) 672-2977 • Fax: (615) 672-2979

Dear Patient,

I want to thank you for choosing Progress In Motion as your outpatient physical therapy provider. Progress In Motion seeks to provide a rehabilitation experience with a Christ-like intensity. In order to fulfill this mission, we want to convey our core values of honesty, integrity, humility, positive encouragement, and compassion in our actions and words at each session with you. By displaying these core values in our relationship with you, we feel an individualized therapy program will result, producing the highest possible outcome for your injury.

We have been entrusted with your care, and we take the prescription, as well as your rehabilitation program, very seriously. Criteria for stopping or discontinuing physical therapy are as follows:

- Meeting goals
- Plateau in progress
- Unsafe behavior
- A condition that is beyond our scope of practice
- Not showing for 3 consecutive appointments
- Your decision to discharge for any reason

We ask if you do have to cancel a physical therapy appointment, to please give us a 24-hour notice or you will be charged a \$30.00 cancellation fee. It is then in your best interest to reschedule that canceled appointment to ensure completion of your prescribed physician visits. Any absences, and all status changes, whether positive or negative, will be reported to your physician and/or your case manager.

Finally, we would like to again thank you for choosing Progress In Motion for your physical therapy services. Your choice enables us to bring a servant-centered physical therapy approach to the White House and surrounding communities. We are both humbled and thankful for the opportunity you give us!

Sincerely,

Daniel W. Headrick, P.T., BS
President, Progress In Motion

I have read and understand that physical therapy is a choice, and my signature below denotes my commitment to the physician prescribed program. **My signature also denotes my understanding that I am financially responsible for my bill, minus insurance payments, including any cancellation fees.**

Patient Signature

Guardian Signature



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PATIENT RIGHTS:

In accordance with government HIPPA regulations, an individual has the following rights with regard to his/her Privacy Health information:

1. The right to consent to or authorize the use and disclosure of Privacy of Health Information.
2. The right to receive a copy of the practice’s Notice of Privacy Practices.
3. The right to request restrictions on certain uses and disclosures of Privacy of Health Information.
4. The right to received confidential communications of Privacy of Health Information.
5. The right to request an amendment of Privacy of Health Information.
6. The right to an accounting of the disclosures of the Privacy of Health Information made by the covered persons for purposes other than treatment, payment or health care operations.
7. The right to complain about alleged violations of the practice to the Department of Health and Human Services.

_____ I have received and read the Notice of Privacy Practices.

Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Please list names of all persons that Progress In Motion may discuss your treatment, payment, attendance, or other healthcare operations (TPO). This discussion could include confirming attendance with a family member, or the need for rescheduling your appointment. If a name does not appear on this list, we cannot release any of your medical information.

Person	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Emergency Contact: _____ Phone #: _____

How did you hear of PIM, Physical Therapy? _____

PIM Physical Therapy Registration Form

PERSONAL INFORMATION:

Patient Name _____ Date of Birth _____ Male / Female

Social Sec. # _____ (Circle One) Married Single Widowed Divorced

Address _____

City _____ State _____ Zip Code _____

E-mail address: _____

Home # _____ Work # _____ Cell # _____

Responsible Party for Medical Expenses (other than self): _____

Responsible Party Address: _____

Responsible Party Date of Birth: _____ Responsible Party SSN: _____

(Circle One) Employed Unemployed Self-Employed Retired Disabled Student

Employer's Name & Address _____

Auto Accident Related? Yes No Job Related? Yes No Date of Injury _____

Is there a Lawyer involved in your case? Yes No Name _____

Address _____ Phone # _____

Have you had Physical Therapy in the past 12 months? Yes No Date of therapy _____

If yes, where did the therapy take place? _____

Referring Physician _____

Date last seen _____

Diagnosis/ Chief Complaint: _____

INSURANCE INFORMATION:

- *Please provide a copy of the insurance card*

Insurance Carrier _____ Secondary Carrier _____

ID # _____ ID # _____

Group # _____ Group # _____

READ CAREFULLY BELOW AND SIGN

- *My benefits are listed below as told to the representative of Progress In Motion by my insurance carrier:*

Verified With _____ Date _____ Effect Date _____

Co-Pay/Co-Ins _____ Ded \$ _____ Amount met \$ _____ OutPocket \$ _____ Amount Met \$ _____

Max Visits/\$ Amt. per Year _____ Non Covered Svc. _____

Is Precert # Required? Yes No Physician Referral Required? Yes No # of Visits Used _____

I hereby authorize this provider of services to furnish my insurance company, including Medicare, with all information requested relating to my illness or injury. I authorize payment to be made to this provider by commercial or government insurance companies for physical therapy treatment and supply expenses rendered from time to time but not to exceed my indebtedness.

I understand that if the injury is work related, that an investigation can either deny or affirm my claim. If denied, I further understand that my health insurance can be billed, and that I am financially responsible for all balances. I understand that if the injury is related to a motor vehicle accident, either my health insurance can be used for payment or I can self-pay.

NOTE: Your financial responsibility listed above is not a guarantee of benefits. The information above was given to us by your insurance company. We encourage you to call and check your benefits with your insurance company. I hereby accept responsibility for charges not covered by my Insurance Carrier. Patient also agrees to reimburse PIM Physical Therapy for reasonable attorney's fees and collection costs in the event they become necessary to collect monies owed to PIM Physical Therapy. My signature below denotes that I understand that I am financially responsible for all expenses incurred, including any deductibles or copays, and according to my payor source guidelines.

Patient/Guardian/Responsible Party: _____

Date: _____

Personal Medical History

Name: _____ Age: _____ Height: _____ Weight: _____
 Referring Physician: _____ Employer: _____
 Occupation: _____

1. ARE YOU RECEIVING ANY HOME HEALTH SERVICES AT THIS TIME? YES NO
2. Do you currently have or have you had any of the following? (Check all that apply)

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnant (current)	<input type="checkbox"/> Smoking
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Fractures/dislocations	<input type="checkbox"/> Sprains
3. Please explain any of the above you checked: _____

4. Current Medications: _____
5. Do you have any condition, which resulted in permanent work restrictions from a physician? Yes No
6. Have you had surgery for your present condition? _____ If yes, when _____
7. Have you had injections for your present condition? _____ If yes, when _____
8. Please list any diagnostic tests _____
9. How did this injury/ problem occur? _____
10. When did this problem start? _____
11. Please rate your pain using a 0-10 scale (0 = no pain; 10 = worst pain imaginable)

a) Current pain _____	b) best pain since onset _____	c) worst pain since onset _____
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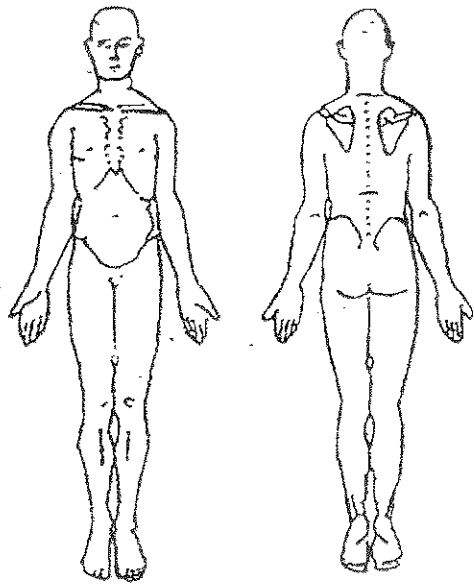
12. How frequent is your pain?

<input type="checkbox"/> Intermittent (comes and goes)
<input type="checkbox"/> Constant (hurts 24 hours/day)
13. What makes your pain better?

14. Please mark on the drawings the areas you feel your symptoms.
15. Are you currently working?

Full	Restricted	Off	Retired	Disabled
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 If restricted or off please explain



16. When are you scheduled to see your physician again?

17. We believe prayer is part of your recovery.
 May we pray for you or with you? YES NO

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give consent to receive physical therapy services at P.I.M. Physical Therapy.

Patient Signature: _____ (Parent/Guardian if under 18): _____
 Therapist Signature: _____