



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,

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

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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.**

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Patient Signature

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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: \_\_\_\_\_

# OPTIMAL INSTRUMENT

## Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. \_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_

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Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.

## 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 \_\_\_\_\_

12. How frequent is your pain?

**Intermittent** (comes and goes)

**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?

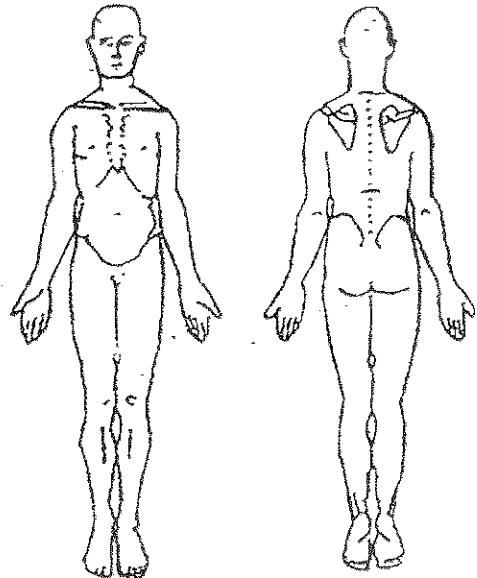
Full Restricted Off Retired Disabled

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: \_\_\_\_\_