



## PERSONAL INFORMATION SHEET

Today's Date: \_\_\_\_\_

### **Personal Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Contact Information:** check best contact number.

Cell phone: (     ) \_\_\_\_\_

Home phone: (     ) \_\_\_\_\_

Work phone: (     ) \_\_\_\_\_ Ext. \_\_\_\_\_

Email address: \_\_\_\_\_

### **Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

### **Other Information:**

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

Referring Physician: \_\_\_\_\_

Referring Physicians Phone: (     ) \_\_\_\_\_

### **Insurance Information:**

Type of Insurance: \_\_\_\_\_

Name on Insurance: \_\_\_\_\_

Address if different from above:

\_\_\_\_\_

\_\_\_\_\_



IF THIS INJURY IS THE RESULT OF AN ACCIDENT INDICATE WHICH:

AUTO\_\_\_\_\_ WORK\_\_\_\_\_

Injury date:\_\_\_\_\_ Claim number if applicable:\_\_\_\_\_

**Parent/Spouse Information if applicable for Insurance:**

Name:\_\_\_\_\_ DOB:\_\_\_\_\_

Address:\_\_\_\_\_

Employer:\_\_\_\_\_

(If Applicable) (Company Name) (Address) (City, State, Zip)

It is the policy of Mindful Movement & Physical Therapy., LLC to provide service to all persons without regard to race, color, national origin, handicap or age in compliance with 45 CFR parts 80, 84 and 91 respectively.

**Insurance Information**

Mindful Movement & Physical Therapy, LLC is a freestanding physical therapy clinic, which means it is not affiliated with a hospital. It is the responsibility of each patient to know his/hers insurance coverage for physical therapy. If you have insurance coverage, in most instances insurance companies cover a percentage of your treatment. Your responsibility will be to cover the copays and/or deductibles.

We are a provider for numerous insurance companies, some of which include: Blue Cross, Medicare, Aetna and some commercial insurance.

Much insurance have a limit to how many visits they will cover. It is best to check and be aware of your coverage.

We will submit all claims to your insurance company or companies unless otherwise instructed. We will also need the name, address and telephone number for all your insurance companies.

If you have questions about the status of your account, please feel free to discuss them with our billing company, Advanced Medical Billing. Their phone number is 517-646-6952.

Thank you for your patience and cooperation.



**Consent for Treatment**

I hereby give consent to Mindful Movement & Physical Therapy to provide evaluative and treatment services as necessary and reasonable for my care.

**Authorization to Release Medical Information**

I hereby authorize Mindful Movement & Physical Therapy to release any information necessary to process this claim.

**Billing Policy**

Mindful Movement & Physical Therapy would like to avoid any problems or misunderstanding with regard to billing.

As a service to our patients, we will submit your claim to your insurance company twice a month. Mindful Movement & Physical Therapy participates with most insurance companies\*. You are responsible for any co-pays and/or deductibles according to your individual policy. Please check with your insurance company for the details of your policy, since ultimately you are the person responsible for the cost of treatment.

As payments are received by us from your insurance company, we will bill you for any co-pays or deductibles that may apply. Please make payment as you receive each bill. If you know paying your balance will be hardship, contact our billing office to work our payment arrangements. If it becomes evident that no effort is being made towards payment, your bill will be turned over to a collection agency. **If you do not pay your bill within 30 days or set up a payment plan with our office we reserve the right to add a monthly fee of 10% of your bill until the balance is paid in full.**

I have read and UNDERSTAND the above and agree to accept responsibility for any balance on my account that is not payable by my insurance company. I give Mindful Movement & Physical Therapy permission to bill my insurance company on my behalf.

\*Not all insurance companies are willing to pay for rehabilitation services at Mindful Movement & Physical Therapy. Again, please check with your insurance company regarding any stipulations.

**Acknowledgement of Notice of Privacy Practices**

I have received and read the Notice of Privacy Practices of Mindful Movement & Physical Therapy (You may request a copy).

**Cancellation Policy**

If you wish to cancel an appointment you must notify our desk staff via phone at LEAST 24 hours prior to the scheduled appointment, and provide the reason(s) for cancellation.

**You will be charged a \$35.00 fee for all cancellations made within 24 hours prior to the scheduled appointment.**

I understand the cancellation policy and agree to be responsible for any cancellation fees.

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I \_\_\_\_\_, have read and understand the above policies.

\_\_\_\_\_  
**Signature** (Guardian if patient is a minor)

\_\_\_\_\_  
Date



With whom do you live?  
 \_\_\_\_\_ Alone  
 \_\_\_\_\_ Spouse/significant other  
 \_\_\_\_\_ Child/children  
 \_\_\_\_\_ Other relative(s)  
 \_\_\_\_\_ Group setting  
 \_\_\_\_\_ Personal Care Attendant  
 \_\_\_\_\_ Other: \_\_\_\_\_

Where do you live?  
 \_\_\_\_\_ Private home  
 \_\_\_\_\_ Private apartment  
 \_\_\_\_\_ Rented Room  
 \_\_\_\_\_ Other: \_\_\_\_\_

Occupation: \_\_\_\_\_

Lost days from work: \_\_\_\_\_

Please list any work restriction:

**Functional Limitations** Please rate the following:

**A. Difficulty**

1. Able to do without any difficulty
2. Able to do with little difficulty
3. Able to do with moderate difficulty
4. Able to do with much difficulty
5. Unable to do
6. N/A

**B. Confidence**

1. Fully confident in my ability to perform
2. Very Confident
3. Moderate Confidence
4. Some confidence
5. Not confident in my ability to perform
6. N/A

	A. Difficulty	B. Confidence
Lying flat	1 2 3 4 5 6	1 2 3 4 5 6
Rolling over	1 2 3 4 5 6	1 2 3 4 5 6
Moving – lying to sitting	1 2 3 4 5 6	1 2 3 4 5 6
Moving – sitting to standing	1 2 3 4 5 6	1 2 3 4 5 6
Sitting	1 2 3 4 5 6	1 2 3 4 5 6
Squatting	1 2 3 4 5 6	1 2 3 4 5 6
Bending/Stooping	1 2 3 4 5 6	1 2 3 4 5 6
Balancing	1 2 3 4 5 6	1 2 3 4 5 6
Kneeling	1 2 3 4 5 6	1 2 3 4 5 6
Walking – short distance	1 2 3 4 5 6	1 2 3 4 5 6
Walking – long distance	1 2 3 4 5 6	1 2 3 4 5 6
Climbing Stairs	1 2 3 4 5 6	1 2 3 4 5 6
Pushing	1 2 3 4 5 6	1 2 3 4 5 6
Pulling	1 2 3 4 5 6	1 2 3 4 5 6
Reaching	1 2 3 4 5 6	1 2 3 4 5 6
Lifting overhead	1 2 3 4 5 6	1 2 3 4 5 6
Lifting from the waist up	1 2 3 4 5 6	1 2 3 4 5 6
Lifting from the floor	1 2 3 4 5 6	1 2 3 4 5 6
Carrying	1 2 3 4 5 6	1 2 3 4 5 6
Self care (bathing, dressing, eating, toileting)	1 2 3 4 5 6	1 2 3 4 5 6
Managing your household chores (shopping, care of dependents)	1 2 3 4 5 6	1 2 3 4 5 6
Driving/transportation	1 2 3 4 5 6	1 2 3 4 5 6
Work/ School	1 2 3 4 5 6	1 2 3 4 5 6
Recreation/ Play	1 2 3 4 5 6	1 2 3 4 5 6