



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.

I _____, have read and understand the above policies.

Signature (Guardian if patient is a minor)

Date



PATIENT QUESTIONNAIRE
ALL INFORMATION IS KEPT CONFIDENTIAL

NAME: _____ DATE: _____

Please answer the following questions as completely and accurately as possible. The information will be useful to our professional staff in your evaluation and treatment program.

1. Please state the date of which you experienced the problem that brought you here today:

2. Describe the pain or difficulty: _____

3. Please list or provide a copy of past medical conditions, including ones you are taking prescribed medication for: _____

4. Current list of medications: _____

5. Functional Limitations (check all that apply)

_____ Limited ability to move in bed

_____ Transfers (such as moving from chair to stand)

_____ Walking: _____ distances

_____ Stair climbing

_____ Self-care (bathing, dressing, eating, toileting)

_____ Managing you household chores, shopping, driving/transportation, care of dependents)

_____ Work/ School

- Recreation/Play
- Lifting overhead
- Lifting from the waist up
- Lifting from the floor

6. Occupation: _____

7. Lost days from work: _____

8. Please list any work restriction: _____

9. Pain

Is your pain constant? _____

Pain with activity? _____

Randomly occurring pain- when: _____

10. Can you sleep through the night: YES _____ / NO _____

11. Do you feel better after you sleep: YES _____ / NO _____

12. Does your pain interrupt your sleep: YES _____ / NO _____

13. Location of pain: _____

14. Rate your pain

0	1	2	3	4	5	6	7	8	9	10
NO PAIN				MODERATE					SEVERE	
				PAIN					PAIN	