Perpetual Motion Physical Therapy, Inc.
Patient Information

Date_____

Patient Information

Name _____
Last First MI

Address _____
Street City Zip Code

Birth Date_____ Age _____ Social Security_____ Sex: ❑ Male ❑ Female

Contact Phone _____ Work Phone _____ Email_____

Employer _____ Occupation_____

Address _____
Street City Zip Code

In case of emergency: Contact Name_____

Relationship_____ Phone Number_____

General Information

Have you been a patient here before? ❑ Yes ❑ No If yes, when? _____
Month, Year

Chose office because/Referred to office by (please check one box): ❑Doctor _____

❑Insurance Plan ❑Family ❑Friend ❑Close to home/work ❑Internet ❑Other _____

Other family members seen here _____

Who referred you to this office? _____

Address_____Phone Number_____

Insurance Information

Insurance Company _____

Name of Insured_____ Relationship of Insured to Patient: ❑ Self ❑ Spouse ❑ Parent

Insured's DOB _____Insured's Social Security Number _____

Personal or Work Injury Claim (ONLY FILL OUT IF YOU HAVE AN ADJUSTER OR HAVE FILED A CLAIM)

Date of Injury _____ ❑ Work Related ❑ Personal Injury

Insurance Company_____ Adjuster's Name _____

Adjuster's Phone Number _____ Claim Number _____

Employer at time of injury _____

Address_____ Case Number _____

Perpetual Motion Physical Therapy
Medical History Questionnaire

Current Medical Providers
Do you have an appointment to return to your referring doctor? ❑No ❑ Yes
If so, when is your next appointment? _____

Please list all physicians whose care you are under. Please include their information as follows:

Doctor's Name _____ Phone Number_____
First Last

Address _____
Street City Zip Code

Doctor's Name _____ Phone Number_____
First Last

Address _____
Street City Zip Code

Doctor's Name _____ Phone Number_____
First Last

Address _____
Street City Zip Code

Medical Health History

1. Have you had treatment for this/these problems before? ❑No ❑ Yes
   If yes, where and when were you treated? _____
2. Have you had surgery related to this/these problems? ❑No ❑ Yes
   If yes, what type of surgery did you have and when was the surgery?
   _____
   _____
   _____
3. Have you had any injections for your current problem? ❑No ❑ Yes
   If yes, location_____
4. Do you currently have any metal implants? ❑No ❑ Yes
5. Do you currently have a pacemaker? ❑No ❑ Yes
6. Do you have any communicable diseases? ❑No ❑ Yes
7. Do you smoke? ❑No ❑ Yes
8. List any medications you are currently taking:
   _____
   _____
   _____
9. In general, would you say your overall health right now is (check one):
   ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Description of Symptoms

Date of Injury or Onset of Symptoms: _____

Describe how your injury occurred or when/how your symptoms began: _____

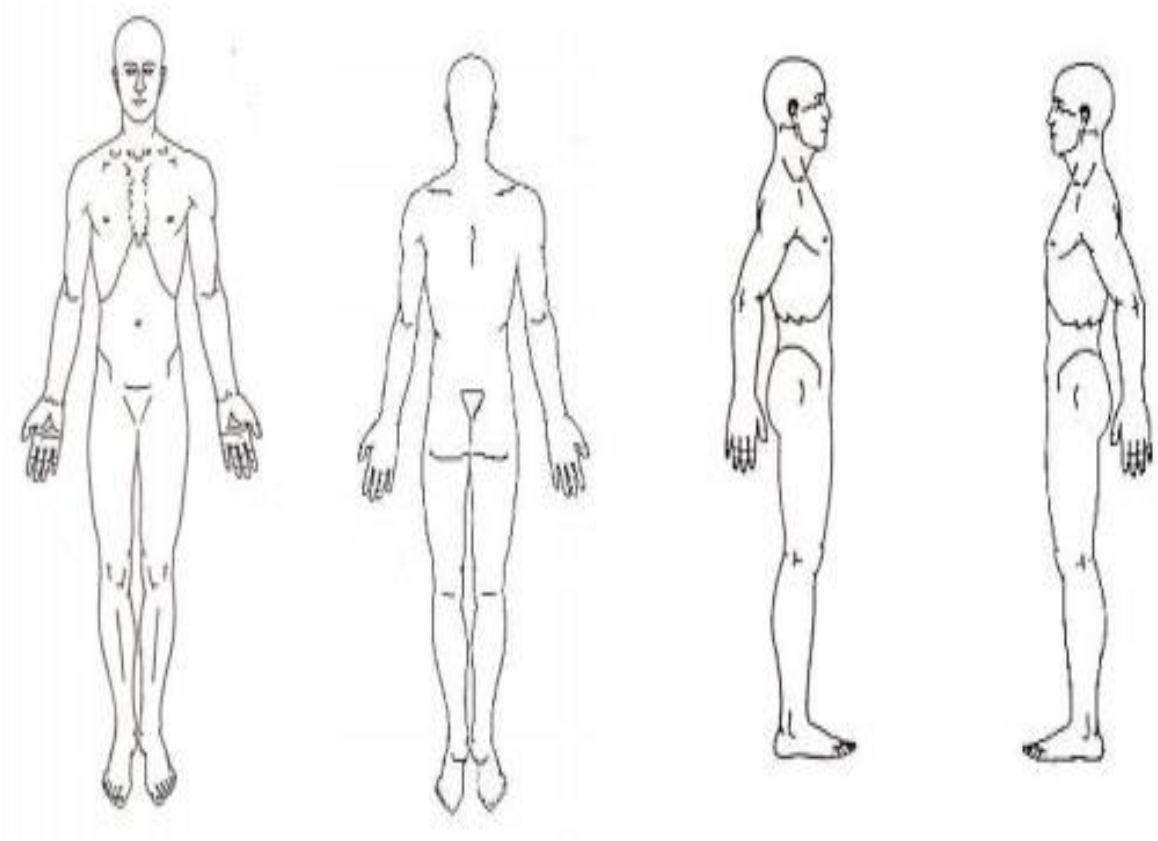
_____

_____

Current Complaint: _____

_____

Please indicate on the diagram where you experience your pain/symptoms.



My pain is increased by: _____

My pain is decreased by: _____

Description of Symptoms (continued)

Type of Pain (check all that apply):

❑Shooting ❑ Burning ❑ Aching ❑ Sharp ❑ Dull ❑ Tingling ❑ Other _____

When do you experience your pain/symptoms? ❑ Morning ❑ Afternoon ❑ Evening
How many times a week? _____
With what activities? _____

What is the frequency of your symptoms (check one)?

❑ Constantly (76-100% of day) ❑ Frequently (51-75% of day)

❑ Occasionally (26-50% of day) ❑ Intermittently (0-25% of day)

How are your symptoms changing (check one)?

❑ Getting better ❑ Not changing ❑ Getting worse

During the past four weeks, the most severe intensity of your symptoms was (circle one):

1 2 3 4 5 6 7 8 9 10

Descriptions of Functional Limitations and Goals:

What activities in your daily life are affected the most by your current complaint (including recreational, social activities, functional activities, and work around the house)? _____

_____

If you have limitations/restrictions at your job, what are they? _____

_____

How much has the pain interfered with your work (check one)?

❑ All of the time ❑ Some of the time ❑ None of the time

What are your goals for the first two weeks? _____

_____

What are your goals at 6-8 weeks? _____

_____

Consent to Treatment and Therapeutic Procedures

I, _____, hereby consent to the therapeutic procedures outlined below, to be performed by Perpetual Motion Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and musculoskeletal training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Perpetual Motion Physical Therapy, Inc. or from any other source.

I certify that I have read, and understand, the above consent statements:

Patient's Signature: _____ Date: _____

Physical Therapist's Signature: _____ Date: _____

Financial Responsibility Policy

I hereby agree to pay my account as provided FEE FOR SERVICE. If for any reason there is a balance owing on my account, I will pay upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through Perpetual Motion Physical Therapy Inc.'s billing department. These arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Perpetual Motion Physical Therapy, Inc. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY PERPETUAL MOTION PHYSICAL THERAPY INC., THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO THE SERVICES PROVIDED. This includes, but not limited to, services deemed 'non-covered' or 'not medically necessary' by my insurance.

Although I have requested Perpetual Motion Physical Therapy Inc. to bill my insurance company on my behalf, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE DIRECTLY TO PERPETUAL MOTION PHYSICAL THERPAY, INC. FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM.

Patient's Signature: _____ Date: _____

Financial Responsibility Policy

I acknowledge that I was provided a copy of the Notice of Privacy Practices that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent/Authorized Representative (if applicable): _____ Date: _____

PERPETUAL MOTION PHYSICAL THERAPY INC.
PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mea n both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physical therapist, and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand of a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by party for such a party's own benefit. The parties agre e that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of a person or entity which would otherwise be a proper additional party in a court action and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physical therapist within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOU RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physical Therapist or Authorized Representative's Signature (Date)

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____

Perpetual Motion Physical Therapy Inc.
Print or Stamp Name of Physical Therapist, Medical Group or Association

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Perpetual Motion Physical Therapy, Inc.

Authorization Responsibility Policy

Effective date of policy: 11/14/2011

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Perpetual Motion Physical Therapy will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.