EW Motion Therapy Homewood LLC
3125 Independence Drive // Suite 300B // Birmingham AL 35209
Ph 205.879.7501 // Fax 205.879.0675 // ewmotiontherapy.com

PATIENT HEALTH AND MEDICAL HISTORY

Today's Date: _____ Chief Complaint for Today's Visit: _____

Was this injury gradual or sudden onset? _____ Date of sudden onset: _____

Please explain: _____

Do you have a history of present symptoms? _____

Have you been to another Physical Therapist or Chiropractor for these symptoms? YES or NO

If yes, please list the dates and the number of visits: _____

Have you had any imaging studies (x-ray, MRI, CT scan, bone scan, etc.) for these symptoms? YES or NO

If yes, please list what study and the date the study was done: _____

Have you had any surgeries related to this injury? YES or NO

If yes, please list the type of surgery and the date of the surgery: _____

Please list all current medications and supplements that you are taking: _____

_____

Have you recently had a significant weight gain or loss? YES or NO Please explain: _____

Is this injury the result of an accident? YES or NO If yes, please list the date of the accident: _____

Please provide a brief description of the accident: _____

Please circle all that apply to you:

Smoker	Pregnancy	IBS	MVP	Asthma/Pulmonary/Lung Condition
Diabetes	Arthritis	Rheumatoid Arthritis	Migraines	Pacemaker/Defibrillator
Heart Conditions	Osteoporosis	High Blood Pressure	Aortic Aneurysm	Internal Electrical Stimulator
Stroke	Lymphedema	Cancer: _____		

Please list any and all surgeries and the date of surgery:

Orthopedic Surgeries:

Orthopedic Extremity: _____ Spine: _____

_____ _____

Cardiovascular: _____ Mastectomy/Breast Reconstruction: _____

_____ Hysterectomy: _____

Gastric Bypass: _____ Cesarean Section: _____

Patients with MEDICARE: Is someone from Home Health coming to your house or did Home Health come to your house? If so, please provide the date of discharge from Home Health. _____

Please list any other medical history we may need to know in order to provide the best treatment possible:

_____

To the best of my knowledge, all the above information is correct.

Signature: _____ Date: _____

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PATIENT INFORMATION SHEET

Patient's Legal Name: _____ Goes By:_____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Sex: M or F Marital Status: _____ Employer: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION **(***We require this information to be filled out in addition to providing a copy of your insurance card(s) and a Photo ID.)*

Primary Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code:_____ Relationship to Patient: _____

Policy Holder's Home Phone: _____ Cell Phone: _____ Work: _____

Secondary Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Address: _____

City: _____ State:_____ Zip Code:_____ Relationship to Patient: _____

Policy Holder's Home Phone: _____ Cell Phone: _____ Work: _____

Is this a work related injury? YES or NO If yes, please provide the Worker's Compensation Information:

Worker's Compensation Provider: _____

Contact Person and Contact Information: _____

Referring Doctor (First and Last Name): _____

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CONSENT FOR PHYSICAL THERAPY

At EW Motion Therapy Homewood LLC we use a variety of physical therapy treatments to help us to try and improve your function. These may include, but are not limited to evaluation, treatment, soft tissue mobilization, therapeutic procedure/exercise, therapeutic activity, ultrasound, electrical stimulation, traction, neuromuscular education, iontophoresis, gait training, activities of daily living, and functional training. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Because physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy, modality, or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may affect previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and testing results. You may also discuss what the potential risks and benefits of a specific treatment might be with your physical therapist. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Inherent physical risks are associated with exercise. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

EW Motion Therapy Homewood LLC also conducts educational activities. I understand that physical therapy students and other health care and post-graduate students may take part in these activities. These students may assist the clinical staff in my care and treatments. Any questions that I may have concerning the role of these students should be directed to the treating physical therapist.

I acknowledge that my treatment program has been explained by EW Motion Therapy Homewood LLC and all of my questions have been answered to my satisfaction. I understand the risks and benefits associated with a program of physical therapy as outlined to me, and I wish to proceed.

_____	_____	_____
Patient Signature	Patient Name (please print)	Date
_____	_____	_____
Authorized Agent Signature	Authorized Agent Name (please print)	Date

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Your Insurance Responsibility

Patients, please check your health insurance policy carefully as it relates to the coverage of Physical Therapy Services. Many policies differ on coverage amounts, deductibles, and percentages paid.

- Many insurance policies cover physical therapy under the major medical portion of the policy.
- Most major medical portions of a policy require a deductible to be met prior to your insurance company initiating payment.
- Deductible amounts vary from policy to policy.
- Once the deductible has been met, then your policy will pay on a percentage basis per visit. **You are responsible for all remaining allowable charges not paid by your insurance**.
- The balance we will collect at each visit includes current claims that have been filed and processed through your insurance.

We recommend you call your insurance company to find out the following information regarding your physical therapy benefits:

- Do I have a deductible?
  - If so, how much is the deductible?
  - How much of the deductible has been met to date?
- Once the deductible has been reached, what is the percentage that is my responsibility?
- What is my benefit year?
- How many physical therapy visits are allowed each benefit year?
- Does my policy require a precertification?

Thank You and we look forward to assisting you in your return to good health!

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EW MOTION THERAPY HOMEWOOD LLC
FINANCIAL AGREEMENT

EW Motion Therapy Homewood LLC is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the Physical Therapists of the practice and the patient. Your clear understanding of the financial policy agreement is important to our professional relationship.

THE FINANCIAL AGREEMENT

We must emphasize that as your physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. It is your responsibility to contact your insurance company to find out your physical therapy benefits.

PAYMENT

Payment is expected at the time of service. This is an insurance company rule. Deductibles, co-payments, and/or co-insurance are your responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.
EW Motion Therapy Homewood LLC accepts cash, personal checks, VISA, MasterCard, and Discover Card. We reserve the right to charge a $30 service charge for returned checks.
Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments.

In the case of separation or divorce, please do not place our office in the middle of marital disputes. The patient or an accompanying parent or adult is responsible for payment at the time of service. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We will send one statement each month to the designated parent. It is the designated parent's responsibility to communicate with the other parent about payment amounts.

VISITS COVERED BY INSURANCE

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. Most insurance plans require a referral from a physician in order to cover services for physical therapy. It is the patient's responsibility to contact his insurance company to find out this information.

CANCELLED APPOINTMENTS

If you are unable to keep your scheduled appointment, please call our office at least 24 hours before your appointment to reschedule. This will allow time for us to provide that time slot to another patient. We reserve the right to charge $50 for appointments that are not cancelled at least 24 hours in advance.
If you do not show up or if you do not cancel in advance for three visits in a row, we will remove your remaining appointments from the schedule without notification to you and we reserve the right to charge $50 for each missed appointment.

MORE INFORMATION

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss your situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent patients from receiving the care they need at the time it is needed. Please contact the Billing Office at 205-263-2770 to discuss your bill.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY EW Motion Therapy Homewood LLC. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN addition TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____	_____	_____
PATIENT OR AUTHORIZED AGENT SIGNATURE	**PATIENT'S NAME (PLEASE PRINT)**	**DATE**

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ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

EW Motion Therapy Homewood LLC has a "Notice of Privacy Practices." Your signature indicates that you have had the opportunity to review and/or receive a copy of our notice. It describes in detail how we might use or disclose protected health information. It also discusses your rights and duties regarding protected health information. If I am not a patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____
Signature of Patient or Authorized Agent Date

_____
Patient's Name (Please Print)

TO BE COMPLETED BY EW MOTION THERAPY HOMEWOOD LLC IF NO ACKNOWLEDGMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgment from the patient or patient's authorized agent. The good faith efforts made and the reason acknowledgment could not be obtained were:

- ☐ Patient (or authorized agent) refused to sign after being requested to do so.
- ☐ Minor presented without parent or authorized agent. NPP, acknowledgment form, and self-addressed envelope sent home with patient.
- ☐ Other: (please describe)_____
  _____

_____ _____
Signature of Staff Member Date