PURE MOTION
physical therapy

PATIENT INFORMATION

First Name _____ MI____ Last Name_____ DOB _____

Address _____ Apt # _____

City _____ State _____ Zip _____ Sex ☐ M ☐ F

Primary Contact Number _____ ☐ Home ☐ Mobile ☐ Work

Secondary Contact Number _____ ☐ Home ☐ Mobile ☐ Work

Email Address: _____

☐ *Please check this box if you do not want to receive email*

How did you hear about us? ☐ Healthcare Provider ☐ Friend/Family ☐ Other _____

Name _____

Emergency Contact _____ Relationship _____ Phone _____

Medical Profile Questionnaire

Briefly describe your symptoms _____

_____

When did your symptoms start? _____

Was there a specific incident? _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

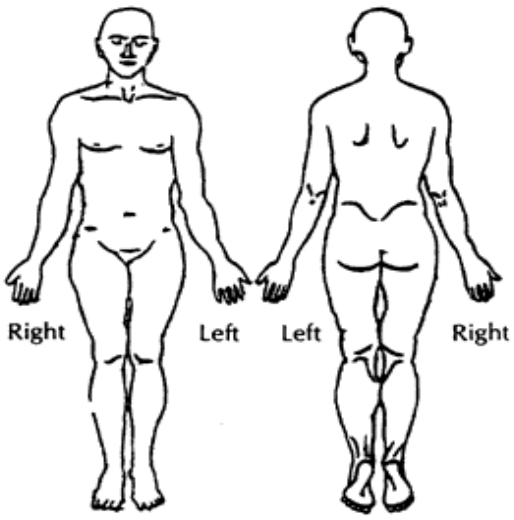
Which best describes the nature of your symptoms?

☐ Sharp
☐ Shooting
☐ Dull ache
☐ Burning
☐ Numbness/Tingling

Are your symptoms changing?

☐ Getting better
☐ Not changing
☐ Getting worse

Indicate on image where pain is located



During the past 4 weeks:

Indicate the average intensity of your pain • *circle one*

0 1 2 3 4 5 6 7 8 9 10

None Moderate Unbearable

How much has pain interfered with your normal work *(including both work outside the home and housework)*

☐ Not at all☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks how much of the time has your condition interfered with social activities?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Have you had previous treatment for this condition? ☐ Yes ☐ No If yes, whom have you seen?

☐ Medical doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other _____

How many visits? _____

How do you spend your day? *(check all that apply)*

☐ Sitting at a desk ☐ Standing at a desk ☐ Light Activity ☐ Vigorous Activity
☐ Light lifting ☐ Heavy Lifting ☐ Other:_____

Referring Physician: _____

Date of last doctor's visit/exam: _____ Date of next visit/exam: _____

Family Physician/Internist: _____ Month/year visit: _____

Check if you currently take any of the following MEDICATIONS:

☐ Steroids (cortisone)	☐ Anti-inflammatory	☐ Pain Killers
☐ Muscle relaxants	☐ Anti-coagulants (blood thinners)	☐ Insulin (diabetes)
☐ Blood pressure meds	☐ Heart medication	☐ Other: _____

I have a history of: *(check all that apply)*

☐Cancer / tumors	☐Heart trouble/Angina	☐Coronary Artery Disease
☐ Pacemaker/nitroglycerin patch	☐ Poor circulation	☐High Blood Pressure
☐ Recent & sudden weight changes	☐ Bruise easily	☐ Stroke
☐ Headaches	☐ Dizziness	☐ Diabetes
☐ Shortness of Breath	☐ Hearing Problem	☐ Arthritis
☐ Asthma	☐ Osteoporosis	☐ Blackouts
☐ Night sweats	☐ Bladder problem	☐ Smoking
☐ Chest, abdominal or pelvic surgery	☐ Epilepsy/seizures	☐ Frequent falls

For WOMEN: *(check if yes)*

☐ I have had a recent pelvic exam (pap)
☐ I am or may be PREGNANT
☐ I have had a recent mammogram or breast exam

For MEN: *(check if yes)*

☐ I have had a recent prostate exam

Patient Name First:_____ Last:_____

Allergies: (e.g. medications, food, adhesive, latex, beeswax, others) Please list allergens and reactions:
_____
_____

History of Surgery: _____
_____
_____

Imaging, X-rays, MRI, CT: (specify by name & date of studies & results if known)
_____
_____

_____ _____
Signature of patient or guardian over 18 Date

_____ _____ _____
Print name if signed on behalf of the patient Relationship Date

Patient Name First:_____ Last:_____

OFFICE POLICIES

OUT OF NETWORK PROVIDER ACKNOWLEDGEMENT

Pure Motion Physical Therapy, PLLC is an out of network provider and therefore does not participate with insurance companies. It is the responsibility of patients interested in seeking care from Pure Motion Physical Therapy to ascertain their outpatient physical therapy benefits prior to receiving treatment. Pure Motion Physical Therapy will provide every patient with an itemized receipt that can be submitted to your insurance company for reimbursement provided that you have out of network benefits, have met the deductible that corresponds with your plan, and have not exceeded your benefits for the calendar year set forth by your insurance provider. To help you determine your benefits we have provided an insurance on our website www.PureMotionPhysicalTherapy.com

PAYMENT AND SERVICES RENDERD

Patients receiving physical therapy at Pure Motion Physical Therapy are expected to pay at the conclusion of each individual treatment session. Cash, check, and charge are all accepted.

NO SHOW/CANCERLATION POLICY

Physical therapy appointment scheduled represent time specifically set aside for you as a patient. All cancellations MUST be made 24 hours prior to the start of your scheduled appointment time to avoid incurring a late fee. Patients who cancel or no show on three separate occasions will automatically discharged from care at Pure Motion Physical Therapy

All cancellations (less than 24hrs notice) and no show appointments will be charged $100 to the credit card kept of file.

CONTACTING PURE MOTION PHYSICAL THERAPY

When you need to contact Pure Motion Physical Therapy (PMPT) for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

- Email Emily@puremotionpt.com
  - ❖ If you wish to communicate with PMPT by normal email or normal text message, please inquire about the potential confidentiality risks of doing so.
  - ❖ If you wish to communicate with us by normal email or normal text message, please read and complete the Consent For Non-Secure Communications form included with these office policies.
- Leave messages on the confidential voicemail (425)247-1841

  If you need to send a file such as a PDF or other digital document, please send it to Emily@puremotionpt.com.

Patient Name First:_____ Last:_____

Please refrain from making contact with PMPT or Emily Scherb using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security and we are not prepared to watch them closely for important messages from patients.

It is important that we be able to communicate so please speak with us about any concerns you have regarding our preferred communication methods.

RESPONSE TIME

We may not be able to respond to your messages and calls immediately. For voicemails and emails, you can expect a response within one to two business days. We may occasionally reply more quickly or on weekends, but this will not always be possible. Be aware that there may be times when we are unable to receive or respond to messages, such as when out of cellular range or out of town.

DISCLOSURE REGARDING THIRD-PARTY ACCESS TO COMMUNICATION

When using electronic communications methods, such as email, texting, online video, and others not specified here, those who maintain these services and may have access to the content of those communications. Be aware that people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages.

Patient Name First:_____ Last:_____

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ (Patient Name) AUTHORIZE: Pure Motion Physical Therapy, PLLC

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:

- ☐ Email communication
- ☐ Text message
- ☐ Other _____

FOR THE PURPOSES OF

- ☐ Scheduling of meetings or other appointments
- ☐ Billing and payment related information

TERMINATION

- ☐ This authorization will terminate _____ days after the date listed below. OR
- ☐ This authorization will terminate when the following event occurs: _____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Patient Name First:_____ Last:_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been informed of my rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Pure Motion Physical Therapy to use and disclose my protected health information in order to:

- Coordinate treatment among healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers (e.g. my insurance company)
- Conduct normal healthcare operations

I have been informed of Pure Motion Physical Therapy's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I have been given the right to review and receive a copy of *Notice of Privacy Practices.* I understand that Pure Motion Physical Therapy has the right to change the terms of this notice from time to time and that I may contact this office at the address below to obtain the most current copy of this notice.

I understand that I have the right to request, in writing, restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations. I understand that Pure Motion Physical Therapy is not required to agree to these requested restrictions. However, if you do agree, you are then bound to abide by such restrictions.

Print Patient Name _____

Signature _____ Date _____

Relationship to Patient (if not self) _____

I give permission for the following individuals to request treatment or account information.

_____

_____

Patient Name First:_____ Last:_____