

**M O V E M E N T
S Y S T E M S**
Physical Therapy, P.S.
(206) 405-1864 (206) 405-4376 fax



PATIENT REGISTRATION – PLEASE PRINT

Patient _____ Today's date _____
Last name First name Middle Initial

Address _____
City State Zip

Email _____

_____ Initial to provide permission to contact you by email.

Phone () _____ () _____ () _____ SSN# _____
Home Work Mobile

Birthdate _____ Sex Male Female Marital Status Single Married Other

Employed Full time Part time Student Full time Part time

Employer/School Name _____ Occupation _____

Employer's address _____
City State Zip

Emergency Contact _____ Relationship to patient _____

Emergency Phone Number () _____ () _____ () _____
Home Work Cell

Patient's relationship to insured: Self Spouse Child Dependent

IF INSURED IS NOT THE PATIENT, PLEASE COMPLETE THIS SECTION:

Name of insured: _____ Birthdate: _____ Sex Male Female
Last name First name M.I.

Insured's address _____
City State Zip

Phone () _____ () _____ () _____ SSN# _____
home work cell

Employer _____ Employer's address _____
City State Zip

PLEASE PROVIDE THE FRONT DESK WITH YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

Primary Insurance _____ ID number _____ Group number _____

Secondary Insurance _____ ID number _____ Group number _____

****MEDICARE PATIENTS: As a non-participating Medicare Provider, we ask for payment at time of service. Please refer to our Medicare Payment Policy****

NOTE: We do not bill for secondary insurance plans. We require this information to ensure your provider is credentialed with your secondary insurance plan.

Name of referring physician or nonphysician practitioner (NPP): _____
First name Last name Designation

Physician/NPP address: _____
City State Zip

Physician/NPP phone number () _____ Fax number () _____

IF THIS IS AN L&I CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION

Labor and Industry Claim Number : _____ DOI: _____

Claim Manager: _____ PHONE () _____

IF THIS IS A PERSONAL INJURY CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION

Name of Auto Insurance Company: _____

Adjuster/Claim Manager Name: _____ DOI: _____

Claims Address: _____
Street City State Zip

Phone () _____ Claim #: _____

❖ Please note that Co-pays are collected at the time of visit.

Patient's or authorized person's signature:

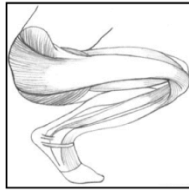
- I authorize the release of any medical records or other information necessary to process this claim.

Signed _____ Date _____

Insured's or authorized person's signature:

- I authorize payment of medical benefits to MOVEMENT SYSTEMS PHYSICAL THERAPY, P.S.
- I am financially responsible for any balance due.

Signed _____ Date _____



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BILLING AND PAYMENT POLICY

Welcome to MSPT. In order to budget for your physical therapy services, we would like to provide you with a brief explanation of our payment policy.

For the best chance of reimbursement from your insurance carrier:

- *We suggest that you contact your insurance company prior to your first appointment to determine your physical therapy coverage and providership stipulations.* Coverage depends upon your insurance company and the specific plan you have chosen. You will need a current doctor's prescription for physical therapy services in order to submit your claim. Referrals are current for 90 days unless otherwise specified.

To assist you in your budget planning:

- The initial evaluation lasts approximately one hour and includes a written report to your referring provider. We are providers for most major insurance companies. Please refer to your individual insurance company for information regarding your physical therapy benefit coverage.
- Subsequent visits are based on your specific time needs with the physical therapist and the specific procedures performed. All treatments are one to one with the physical therapist.
- **Note:** Fees fluctuate depending on the procedure performed. You may contact our Billing and Collection Coordinator, at 206-405-1864, ext. 105 or via email at info@movementsystemspt.com for more information.

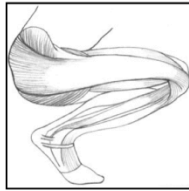
Payment plans are available upon request. Please contact our Billing and Collection Coordinator for terms of a payment plan. **Co-pays are due at the time of service.**

Note: For patients without insurance coverage, or for those patients that have exceeded insurance benefits, a 20% discount is available for full payment at the time of service.

Interest fees are applied to patient accounts exceeding 30 days past due. A fee of \$25 will be charged for any check returned by the bank for Non Sufficient Funds.

I understand my financial responsibilities as described above.

Signature _____ **Date** _____



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MEDICARE PAYMENT POLICY

Welcome to Movement Systems Physical Therapy, P.S. In order to budget for your physical therapy services, we would like to provide you with a brief explanation of our Medicare payment policy.

Since we are a non-participating provider with Medicare, we ask that our Medicare patients pay in full at the time of service. You will only be charged 115% of the Medicare allowable per Medicare guidelines. Medicare will directly reimburse you the Medicare allowable portion, less your 20% co-payment.

At this time, MSPT does not bill your Medicare Supplemental (Medigap) Insurance. Contact the Center for Medicare Services for more information regarding reimbursement from your Medigap plan. <http://www.cms.gov/home/medicare.asp>

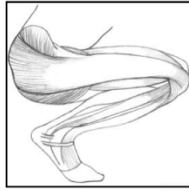
Remember, for Medicare to pay for your treatments, you must meet the following criteria:

1. Your current treatment plan **must have nothing to do with an automobile accident claim, legal case or be covered by your employer’s medical policy.**
2. If you schedule therapy without a physician’s prescription/referral, we MUST obtain a signed physical therapy plan of care from your physician within 30 days of your initial visit.
3. **You MUST be discharged from any home health care services** or agency prior to initiating outpatient physical therapy. Medicare will not pay for both home health and outpatient care simultaneously.
4. The benefits in the Medicare Part B program changes each year. Each year they specify a dollar limit cap for outpatient physical therapy in all settings outside of a hospital rehab department. The means that your physical therapy visits will be limited by medical necessity or approximately 16 visits at MSPT. If your condition requires care beyond that, we can continue to treat you utilizing the Medicare exception rules, however it is important to know that they may deny these extended visits. The cap for the current year **2011** is **\$1870.00**

If you have any questions regarding this policy Please feel free to contact our Financial Coordinator at (206) 405-1864 ext. 105 or via email at info@movementsystemspt.com .

By signing this document you indicate that you have read and understand our Medicare payment policy.

Signature _____ Date _____



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CANCELLATION POLICY

**PLEASE READ THIS POLICY BEFORE YOUR FIRST APPOINTMENT.
YOU WILL BE ASKED TO SIGN THIS POLICY AT THE TIME OF YOUR FIRST
APPOINTMENT.**

Patients are seen, at Movement Systems Physical Therapy, P.S., by appointment only. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments in four to six week intervals.

In the event you need to cancel an appointment, we request at least **24 business hours notice**. Your appointment time is very important to us. If we do not get at least 24 business hours notice of your cancellation, we may not be able to schedule another patient who may need that time slot. This is detrimental to us and to the patients we try to serve.

Unfortunately, we have experienced patients canceling with less than 24 business hours notice or not showing for appointments. Therefore, we have found it necessary to institute a **\$50 cancellation fee** for patients scheduled for a 55 minute session who fail to provide **24 business hours advance notice** (\$25 for 30 minute appointments).

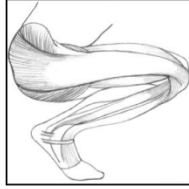
Repeated late cancellations or no shows are disruptive to the optimal delivery of care and may indicate a lack of commitment to your health and wellness. As a result, **2 late cancellations or no shows**, will result in **discontinuing** physical therapy. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy. We realize that emergencies do occur – late cancellation due to illness or family emergency is **excluded** from this policy.

Arriving on time for your appointment is also critical to the optimal delivery of care. Chronic late arrivals are disruptive to the successful implementation of your patient care plan. Arriving more than **7 minutes late for 2 or more visits** may result in **discontinuing** physical therapy. In that event, your referring provider or case manager will be notified of the reason for discharge from physical therapy.

Reading and signing this policy states you understand this policy. All late cancels and no shows not excluded from this policy will be billed to you, holding you responsible for paying these fees.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

Signature _____ **Date** _____



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PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-[arty payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of Movement Systems Physical Therapy’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of *Notice of Privacy Practices*. I understand the Movement Systems Physical Therapy has the right to change the *Notice of Privacy Practices* and that I may contact this office at the above address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that Movement Systems Physical Therapy is not required to agree to my requested restrictions, *but if you do agree* then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient if not self: _____

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

*****For Office Use Only*****

We were unable to obtain the patient’s written acknowledgment of our *Notice of Privacy Practices* due to the following reasons:

Signature

Date

Movement Systems Physical Therapy, P.S.
3221 Eastlake Avenue East, Suite 110
Seattle, WA 98040
206-405-1864
www.movementsystemspst.com

Today's Date: _____

INITIAL EVALUATION INTAKE FORM

1: Name: _____

Last _____

First _____ MI _____ Jr/Sr _____

2: Date of Birth:
Month Day Year

3: Sex: male female

4: Are you: Right-handed Left handed

5: Type of Insurance: Insurer _____
 Labor & Industry Medicare Self-pay Other: _____

6: Race:
 American Indian or Alaska Native Hispanic or Latino
 Asian Native Hawaiian or other
 African American Pacific Islander: _____
 White

7: Education: (check highest level achieved)
 Some High School Some college / Technical school
 College graduate Graduate school / Advanced degree

SOCIAL HISTORY

8: Cultural / Religious: Any customs or religious beliefs or wishes that might affect care? _____

9: With whom do you live?
 Alone
 Spouse only
 Spouse and children: # Children: _____
 Children only: # Children: _____
 Other relatives (not spouse or children)
 Group setting
 Personal care attendant
 Other: _____
 Ages of children living at home: _____, _____, _____, _____, _____

10: Who referred you to us?
 Physician Physical Therapist
 Claims Manager Attorney
 Insurance Co. Yoga Instructor
 Pilates Instructor Personal Trainer Other: _____

11: Employment / Work / (Job / School / Play)
 Working full-time outside of home Working part-time outside of home
 Working full-time from home Working part-time from home
 Homemaker Student Retired Unemployed
 Occupation: _____

12: SOCIAL/HEALTH HABITS

Smoking

(1) Currently smoke tobacco? No Yes
(2) Yes 1. Cigarettes:
packs per day <1 >1
2. Cigars/Pipes:
per day 1 >1

(2) Smoked in the past? No Yes Year quit:

Alcohol

(1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? 0 1 2 3 4 5 6+
(2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? NA 1 >1

Exercise

Do you exercise beyond normal daily activities and chores?
 No
 Yes Describe the exercise(s): _____

(1) On average, how many days per week do you exercise or do physical activity? 1 2 3 4 5 6 7

(2) For how many minutes, on an average day?
<20 20 30 40 >40

LIVING ENVIRONMENT

13: Does your home have? 14: Do you use?
 Stairs, no railing Cane
 Stairs, railing Walker
 Ramps Manual wheelchair
 Elevator Motorized wheelchair
 Uneven terrain Glasses, hearing aides
 Assistive devices (eg, bathroom): _____
 Any other obstacles: _____

15: Where do you live?
 Private home / Condo Private apartment Other: _____

GENERAL HEALTH STATUS

16: Please rate your health:
(1) Excellent (2) Good (3) Fair (4) Poor

17: Have you had any major life changes during the past year? (eg., new baby, job change, death of a family member) Yes No

18: MEDICAL / SURGICAL HISTORY

(1) Please check if you have ever had:
 Arthritis Multiple sclerosis
 Broken bones/ fractures Muscular dystrophy
 Osteoporosis Parkinson disease
 Blood disorders Seizures / epilepsy
 Circulation / vascular problems Developmental or growth problems
 Heart problems Allergies
 High blood pressure Thyroid problems
 Lung problems Cancer
 Stroke Infectious disease (eg., HIV, tuberculosis, hepatitis)
 Diabetes / high blood sugar Kidney problems
 Low blood sugar / hypoglycemia Repeated infections
 Head injury Ulcers/stomach problems
 Depression Skin diseases
 Other: _____

(2) Within the past year, have you had any of the following symptoms? (Check all that apply)

Chest pain Difficulty sleeping
 Heart palpitations Loss of appetite
 Cough Nausea / vomiting
 Shortness of breath Bowel problems
 Dizziness or blackouts Weight loss/gain
 Coordination problems Urinary problems
 Weakness in arms or legs Fever/chills
 Loss of balance Headaches
 Difficulty walking Hearing problems
 Joint pain or swelling Vision problems
 Pain at night Other: _____

Today's Date: _____

INITIAL EVALUATION INTAKE FORM (cont.)

Name: _____

(3) Have you ever had surgery? Yes No
If yes, please describe, and include dates:

Month Year

(4) For men only: Have you been diagnosed with prostate disease? Yes No

(5) For women only: Have you been diagnosed with:

- Pelvic inflammatory disease Endometriosis
- Trouble with your period Complicated pregnancies or deliveries

Other gynecological or obstetrical difficulties
If yes, please describe: _____

19: CURRENT CONDITION(S) / CHIEF COMPLAINT(S)

(1) Describe the problem(s) for which you seek physical therapy: _____

(2) Have you experienced any of the following with your current problem? Locking Giving way Buckling

- Unconsciousness Lip numbness Dizziness/blurred
- Incontinence/difficulty urinating Dislocating
- Loss of balance dropping things
- Pain with cough/sneeze Numbness around groin/buttocks

(4) What is the frequency of your pain?

- Constant Less than 4X/day Greater than 4X/day
- Less than 4 X/week Greater than 4X/week No pain

(5) Does your pain awaken you at night? Yes No
If yes, how many times per night? 1 2 3 > 3

(6) Do you have days or periods of time when you are completely pain free? Yes No

Month Year

(7) When did these problem(s) begin? _____

(8) Was the onset gradual? Yes No

(9) If there was an injury, describe the injury: _____

(10) Have you ever had the problem(s) before?

No
 Yes
(a) What did you do for the problem(s)? _____

(b) Did the problem(s) get better? Yes No

(c) About how long did the problem(s) last? _____

(11) How is your current condition progressing overall?

- Improving Staying the same Getting worse

(12) What makes the problem(s) better? Heat Ice Rest

- Medication Change in position Exercise Other: _____

(13) What makes the problem(s) worse? sitting walking
 twisting bending squatting stairs rising from chair push/pull standing kneeling reaching lifting reclining
 Other: _____

(14) Are you able to continue working? Yes, full duty

Yes, light duty No Last day worked? Month Year

(15) Are you able to continue your usual recreational activities? Yes No Limited - Explain: _____

(16) Have you seen in the past, or are you currently seeing, anyone else for the problem(s) (check all that apply):

- Acupuncturist Orthopedist
- Chiropractor Osteopath
- Dentist Pediatrician
- Family practitioner Podiatrist
- Internist Neurologist/Neurosurgeon
- Massage Therapy Rheumatologist
- Obstetrician/gynecologist Physiatrist
- Occupational therapist Rheumatologist
- Other: _____

20: MEDICATIONS

(1) Do you take any Physician-prescribed medications? (check all that apply)

- Aspirin Anti-inflammatories
- Tylenol/acetaminophen Muscle Relaxers (eg. Valium)
- Prescribed pain relievers Birth control pills
- Hormone replacement therapy High blood pressure medications
- Stomach ulcer pills Water pills (diuretics)
- Antibiotics Heart medications (other than for high blood pressure)
- Thyroid medication Asthma medication
- Antidepressant medication Insulin
- Seizure medication decongestants/antihistamines for sinus or allergy problems
- Other: Please list: _____

(2) Do you take any nonprescription medications?

- (check all that apply)
- Advil/Aleve Antacids (eg. Tums)
 - Motrin/Ibuprofen Decongestants
 - Antacids Herbal supplements
 - Ibuprofen/Naproxen Tylenol/acetaminophen
 - Antihistamines Other: Please list: _____
 - Aspirin _____
 - Tagamet, Zantac, Pepsid _____
 - Laxatives _____

(3) Have you taken any medications previously for the condition for which you are seeing the physical therapist?

- Yes No If yes, please list: _____

21: OTHER CLINICAL TESTS: Within the past year, have you had any of the following tests? (check all that apply)

- Angiogram Echocardiogram Spinal tap
- MRI EEG (electroencephalogram) Stool tests
- Arthroscopy EKG (electrocardiogram) Stress test (eg. bike or treadmill)
- Biopsy EMG (electromyogram) Urine tests
- Blood tests MRI X-rays
- Bone scan Myelogram NCV (nerve conduction velocity)
- Bronchoscopy Pulmonary function test Other: _____
- CT scan _____

THANK YOU!

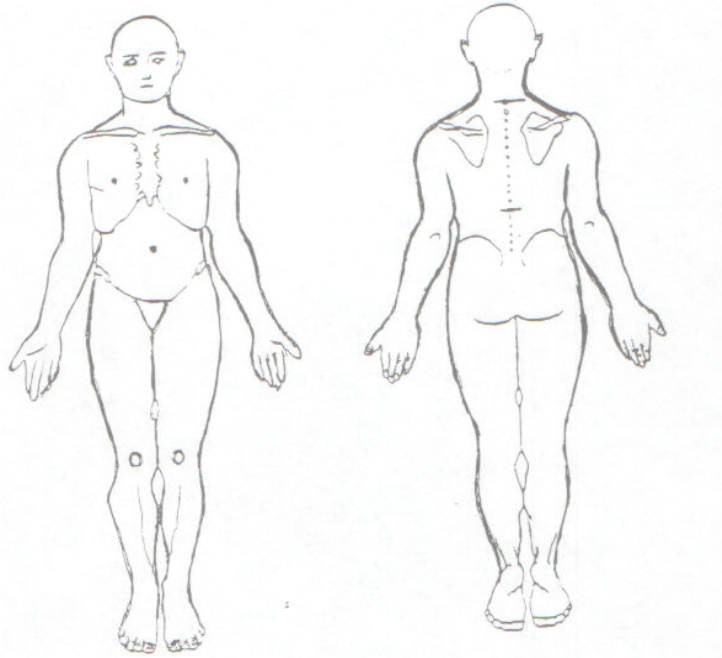
Name: _____ **Date:** _____ **Visit #:** _____

FUNCTIONAL STATUS QUESTIONNAIRE

The following information lets us know how you are doing **TODAY**. Please complete this **3 PAGE** questionnaire. We understand that by limiting your responses to how you are today, we may be catching you on a particularly good or bad day.

Pain diagram

Draw with / marks on the figures below where you feel pain **TODAY**. Use X marks to show where you feel numbness, tingling, or pins and needles **TODAY**.



Visual Analog Scale

Circle the face corresponding to the amount of pain you feel **TODAY**. These faces show how much pain you are experiencing. The face on the far left indicates no pain. The faces show increasingly more pain up to the one on the far right, which is the worse pain. Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.'



0 ----- 2 ----- 4 ----- 6 ----- 8 ----- 10

OPTIMAL

(Outpatient Physical Therapy Improvement in Movement Assessment Log)

Difficulty Instrument
(effort, struggle, exertion)

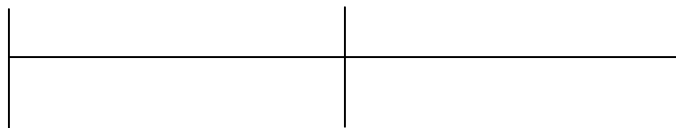
Name: _____ Date: _____ Visit #: _____

Instructions: Please circle the level of <i>difficulty</i> you have for each activity TODAY.	Able to do without any difficulty	Able to do with little difficulty	Able to do With moderate difficulty	Able to do With much difficulty	Unable to do	Not Applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving- lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking- short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. From the above list, choose 3 activities you would most like to be able to do *without any difficulty*. For example, if you would most like to be able to *climb stairs, kneel, and stand*, without any difficulty, you would choose: 1. 12 2. 8 3. 5. List the activities in prioritized order of importance to you.

1. _____ 2. _____ 3. _____

23. Thinking about all of the activities you would like to do, please mark an **X** at the point on the line that best describes your overall level of difficulty with these activities.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

For Office Use Only: _____ = trunk subscale Score: _____
 _____ = lower extremity subscale Score: _____
 _____ = upper extremity subscale Score: _____
 Total: _____

Confidence Instrument
(certainty, trust, belief)

Name: _____ Date: _____ Visit #: _____

Instructions: Please circle the level of confidence you have for doing each activity TODAY .	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving- lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking- short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking of *all* the activities you like to do, please mark a **X** at the point on the line that best describes your *overall* level of **confidence** in performing these activities today:



I have **no confidence** that I can do activities that I would want to do.

I have **complete confidence** that I can do activities that I would want to do.

For Office Use Only:	<u> </u> = trunk subscale	Score: <u> </u>
	<u> </u> = lower extremity subscale	Score: <u> </u>
	<u> </u> = upper extremity subscale	Score: <u> </u>
		Total: <u> </u>