TheraMove & Diagnostics LLC
Phone: 410-823-MOVE (6683)/Cell: 410-831-9616/Fax: 410-823-7684
info@theramovedx.com www.theramovedx.com

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

Name:	Last Name	First Name			Today's date:				
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

INSURANCE HOLDER EMPLOYMENT INFORMATION		
Name of insured if other than patient:		
SSN:	DOB:	Relationship:
Employer:	Occupation:	
Address:		Phone:
City, State, Zip:		
Primary (main) insurance company:		
Effective date:	Expiration date:	
Insurance ID number:		
Group ID number:		
Secondary (supplemental) insurance company:		
Effective date:	Expiration date:	
Insurance ID number:		
Group ID number:		

Acknowledgement
I understand that if any changes are made to my personal or insurance information, it is my responsibility to inform the facility of said changes in a timely manner.
Patient Signature: _____

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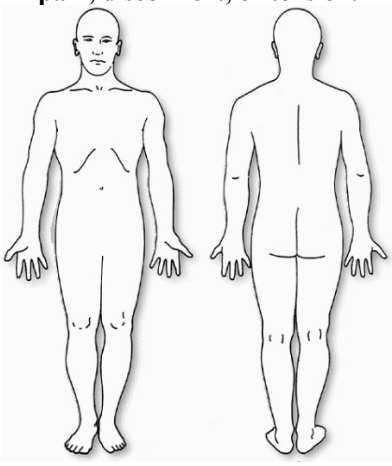
The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.		
	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

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List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

ALLERGIES: List any medications you are allergic to:
_____

Are you latex sensitive? ☐ Yes ☐ No

List any other allergies we should know about: _____

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?				Yes	No
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

110 West Rd, Suite 201, Building A, Towson MD 21204

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If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**
I stand for		**minutes before needing to sit**
I sit for		**minutes before needing to change positions/get up**

Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

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PATIENT'S CONSENT FOR CARE AND TREATMENT

I, the undersigned, am seeking physical therapy and/or diagnostic services as a patient from TheraMove & Diagnostics LLC, located at 110 West Rd, Suite 201, Building A, Towson, MD 21204.

I am aware that TheraMove & Diagnostics LLC provides physical therapy and diagnostic services. I fully understand that in order to perform physical therapy and/or diagnostic services, TheraMove & Diagnostics LLC is providing me services that are beneficial in nature which are being performed at my request and authorization.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL TheraMove & Diagnostics LLC SERVICES

I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand TheraMove & Diagnostics LLC will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for TheraMove & Diagnostics LLC to take action to secure payment of an outstanding balance owed.

I understand that as a patient requesting services, I will have obligations to provide pertinent and relevant information to TheraMove & Diagnostics LLC. Part of that is to fully discuss any limitations of coverage that any company or insurer covering my bills may have to extend of treatment or services, limitations on treatment and/or prescriptions for examinations or treatment or medications. By signing at the end of this form I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I am here for my own health needs.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my therapist the nature and purpose of Physical Therapy and Diagnostic treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations. I consent to the Physical Therapy treatments offered or recommended to me by my Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care.

I understand that TheraMove & Diagnostics LLC has an absolute right to receive payment for their services, therefore, whether or not my insurer or medical plan covers their treatment. I agree to pay any amount not covered by any insurer or medical plan for services provided by TheraMove & Diagnostics LLC.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled, to TheraMove & Diagnostics LLC A photocopy of this assignment is to be considered as valid as the original.

In the event my insurance carrier does not accept this document as an Assignment of Benefits, or if payments are made directly to me, I agree to and will endorse such payments

to TheraMove & Diagnostics LLC within five (5) days of receipt of such payment. I also agree to sign any other forms required by my insurance to comply with their documentation of my claim.

In furtherance of assuring payment for services rendered, I Authorize that the payment of my insurance benefits be made directly to TheraMove & Diagnostics LLC for all services delivered; if I am paid directly, I will promptly pay TheraMove & Diagnostics LLC all monies paid to me.

I assign to TheraMove & Diagnostics LLC any and all benefits payable by my insurance or health care plans. Including medical payments coverage, as a result of charges incurred by myself for services rendered by TheraMove & Diagnostics LLC. I also assigns to TheraMove & Diagnostics LLC any and all contractual rights I have against my insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of my care costs incurred by me as a result of services rendered by TheraMove & Diagnostics LLC. I further guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.

GUARANTEE OF PAYMENT

I understand that all payments designated as 'the patient's responsibility' such as coinsurance and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.

REVOCATION OF AUTHORIZATIONS:

I understand and have been advised that I may revoke these authorizations, if done in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

By signing at the end of this form, I hereby authorize the benefit assignment and authorize TheraMove & Diagnostics LLC to provide all documents required to apply for such benefits and for TheraMove & Diagnostics LLC to release of all information necessary, including Medical Records, to secure payment.

CERTIFICATION OF INFORMATION

I certify that the information I have provided TheraMove & Diagnostics LLC for payment for their services, including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful. In the event that my personal information, insurance, benefit plan or medical physician requesting the treatment changes that I will notify TheraMove & Diagnostics LLC within fifteen days of such change so that they can properly document their file, be up to date with my treatment and communicate with the proper carrier for payment.

POTENTIAL BENEFITS

It is hoped that I will experience improvement in my symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, TheraMove & Diagnostics LLC intends to work with me to educate me about my condition throughout my treatment period. I understand that I may receive this education verbally, visually or through handout material that I may be able to refer regarding proper techniques and home program execution. I understand that these resources are being provided to help me achieve a reasonable level of function and assist me in minimizing my symptoms, should they reoccur.

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POTENTIAL RISKS

As part of any treatment, I understand that as in any activity in which body parts are moved, I may experience an increase in my current level of pain, if pain is part of my complaints. Many times, increased activity or therapy interventions will bring on some discomfort, this is usually temporary. I acknowledge that I have been advised that if my pain or discomfort does not subside within twenty-four (24) hours, I should discontinue any home program involving that activity, if applicable, and immediately contact my therapist at TheraMove & Diagnostics LLC. If they are not available and the pain is substantial, I should seek emergency medical attention.

ALTERNATIVES TREATMENT MAY BE REQUIRED

TheraMove & Diagnostics LLC has established a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. As a patient, I understand that I have the right and responsibility to communicate any unfavorable reaction I experience to any aspect of my treatment so that TheraMove & Diagnostics LLC can modify or terminate it promptly and so that my rehabilitation can progress smoothly and efficiently. If I decide not to continue my participation in my therapy program, TheraMove & Diagnostics LLC will request me to consult with your physician about other treatment alternatives.

NO WARRANTY

As individuals may respond differently to the same treatment, no matter how beneficial, I understand that there can be no guaranty of success or complete symptom abatement. Please note that TheraMove & Diagnostics LLC does not and cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

ACKNOWLEDGMENT AND CONSENT TO PHYSICAL CONTACT

In order to allow TheraMove & Diagnostics LLC to perform their treatment as trained and authorized by my physician, I understand that part of my physical therapy treatment or diagnostic care may require physical contact between a therapist and a patient.

I, by signing this Consent for Care and Treatment understand and acknowledge that part of TheraMove & Diagnostics LLC ‘s treatment and diagnosis may require one or more of their staff to perform services in which someone may touch my body. I understand, acknowledge and affirm that such rehabilitation, physical therapy, diagnostic and/or related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand that touching in the course of treatment will be appropriate. I consent to all appropriate physical contact.

I, by signing this Consent for Care and Treatment, state affirmatively that I, having legal authority to do so, do hereby agree and give consent for TheraMove & Diagnostics LLC staff and therapists to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her condition. While doing so, I agree and affirm that all appropriate therapeutic touching of my body has my consent.

SCHEDULING AND CANCELLATION POLICY

I acknowledge that I have been advised by TheraMove & Diagnostics LLC that it is my duty to be compliant in treatment, and to keep my appointment, as consistent treatment will expedite my recovery. I have been advised that I should require TheraMove & Diagnostics

LLC at least 24 hours' notice, excluding Saturday and Sunday to cancel an appointment. I have been advised that Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $40.00 charge for each occurrence. Arrival more than 30 minutes after the time of your scheduled appointment may be considered a failed appointment.

NOTICE OF RIGHT TO PRIVACY

I acknowledge that I have the right to privacy concerning any health matter. I have been made aware of and am in receipt of the Notice of Privacy Practices, Patient's Rights, Consent to Marketing Materials and Testimonial Release, and HIPAA Authorization for Disclosure of Protected Health Information. I have been asked to review this entire Consent and if executed by myself confirm my acceptance of all terms and conditions. If I do not agree with any portion, I understand that it is my obligation to discuss that section with TheraMove & Diagnostics LLC and resolve any issue with the language or request that I may have prior to receiving services.

I further understand that if I do execute this consent TheraMove & Diagnostics LLC has the right to rely on their understanding that I reviewed, understand and agree with all of its terms and conditions.

After reading and considering the following and fully understanding the document or after discussing my concerns with TheraMove & Diagnostics LLC and had my questions answered to my satisfaction, do knowingly consent to rehabilitation and related services at TheraMove & Diagnostics LLC and I acknowledge that consent by signing this document below.

I have read the above information and I consent to the evaluation(s) and treatment provided by TheraMove & Diagnostics LLC

_____ Signature

_____ Patient Name

_____

_____ Patient Address

_____ Date

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Diagnostic Testing Screening Tool

Patient Name:_____ Date: _____

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist determine what diagnostic tests* might be appropriate for you.

Please check all that apply:

	Low Back and Radiating Pain		***Neck Pain and Radiating Pain***
	Numbness, Tingling or Burning Sensation in the Legs or Feet		***Numbness, Tingling or Burning Sensation in the Arms or Hands***
	Weakness in the Legs or Arms		***Loss of sensation in Hands / Feet***
	You have Diabetes or Neuropathy		***Daily alcohol 3 glasses or more***
	Thyroid Dysfunction		***Muscle Disease / Muscle Cramping***
	Tendinitis / Bursitis / Arthritis		***Shoulder Pain or Instability***
	Elbow Pain or Instability		***Wrist-Hand Pain or Instability***
	Hip or Knee Pain or Instability		***Ankle – Foot Pain or Instability***
	Blurred Vision		***Hearing Problems***
	Dizziness or Vertigo		***Headaches***
	Unsteady gait		***History of falls due to dizziness***
	Hypertension		***Hypotension***
	Anything else you consider important:		

Patient Signature: _____

****Electromyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.***