Life In Motion
PHYSICAL & HAND THERAPY

PATIENT INTAKE FORMS

Welcome to Life In Motion Physical & Hand Therapy. Please fill in the information on these forms to the best of your ability and please see the front desk for assistance or questions. We are happy to have you as part of the LIM family and look forward to assisting you in your journey to recovery.

Please print. **Today's date:** _____

Patient Name: _____ Gender: ☐M ☐F Date of Birth: ____/____/____

Patient's SS#: _____-_____-_____ Age: ____

Please list your preferred method of contact:

Home phone: _____

Work phone: _____

Cell phone: _____

E-mail: _____

Marital Status: ☐ Single ☐Married ☐Widowed ☐Divorced ☐Separated

Mailing address:
_____
_____
City: _____
State: _____
Zip: _____

Emergency Contact name: _____ **Phone:** _____

Relationship: _____

Occupation: _____ **Name of employer:** _____

Are you currently working? Y or N (please circle)

Are you allergic to the following:

Latex? Y or N (please circle)
Adhesive? Y or N
Iodine? Y or N
Silver? Y or N

Do you currently smoke or use tobacco products? Y or N
Do you have a pacemaker? Y or N
Do you have any metal stents in your body? Y or N

What made you choose Life In Motion as your therapy provider?

☐ I am a previous patient ☐ Website ☐ Facebook/Twitter ☐ Workshop at Life In Motion
☐ Referred by physician ☐ Newsletter ☐ Google Reviews ☐ Workshop at another business
☐ Referred by Work Comp ☐ Other _____
☐ Found/sent through my insurance network
☐ Referred by previous patient (write their info in below)

Name: _____ Phone #: _____

Guarantor

If you are filling out information on these forms on behalf of the patient, please input your information below. This applies if you are a parent, power-of-attorney, etc.

Guarantor name (print) _____ Date of Birth: _____/_____/_____

SS#: _____-_____-_____ Guarantor's Phone Number: (_____) _____ - _____

Relation to patient: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company: _____ Plan: _____

Name of insured party of other than patient: _____ D.O.B of insured party ___/___/___

Policy #: _____Group #: _____

Insurance Claim Address: _____

City: _____ State: _____ Zip:_____

SECONDARY INSURANCE

Insurance Company: _____ Plan: _____

Name of insured party of other than patient: _____ D.O.B of insured party ___/___/___

Policy #: _____Group #: _____

Insurance Claim Address: _____

City: _____ State: _____ Zip:_____

FINANCIAL RESPONSIBILITY

As a courtesy to our patients, a representative from Life In Motion Physical and Hand Therapy will call your insurance company to verify your particular therapy/DME benefits. However, it is ultimately the responsibility of the patient to be aware of how their own insurance pays for these services. As of ___/___/___, a representative from your insurance company has informed us they will cover therapy/DME as follows:

PRIMARY	SECONDARY	DME
AVAL BENEFITS: _____	AVAL BENEFITS: _____	_____
COPAY: $_____	COPAY: $_____	_____
DED: $ _____	DED: $ _____	_____
CO-INS: _____	CO-INS: _____	_____
OOP: $ _____	OOP: $ _____	_____

Please note that the information received in an estimation only based upon the website or telephone confirmation at the time of the inquiry. Only when your claim is submitted and then processed by your insurance company will your full and final responsibility be determined. Despite the accuracy of the benefits verified above, I understand and agree that I am ultimately responsible for the charges incurred at Life In Motion Physical and Hand Therapy.

Patient/Guarantor Name (print): _____ Date: _____ / _____ / _____

Patient/Guarantor Signature: _____

CONSENT TO EVALUATION/TREATMENT
INSURANCE ASSIGNMENT, RECORDS AUTHORIZATION, AND INFORMATION ACKNOWLEDGEMENT

I hereby consent to evaluation and treatment as deemed medically necessary by my referring physician. I hereby authorize Life In Motion Physical and Hand Therapy to furnish patient health information concerning my relevant medical history (including but not limited to the super confidential information listed above) to any of the following: other healthcare providers involved in my care, insurance carriers, attorneys and adjustors. I hereby assign Life In Motion Physical and Hand Therapy all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance. I acknowledge that, to the best of my knowledge, the information in this form is accurate and complete.

Patient/Guarantor Name: _____ DATE: _____/_____/_____

Patient/Guarantor Signature (if applicable) _____

PARENTAL RELEASE (IF PATIENT IS A MINOR)

I, _____(legal guardian's name), hereby authorize Life In Motion Physical and Hand Therapy and its employees to release any or all patient health information including super confidential information regarding my child to the person(s) listed below: *(EXAMPLE: A relative or someone other than a legal guardian may accompany your child on a future appointment).*

Name: _____ Relationship to Patient: _____ Ph (____) _____-_____

Name: _____ Relationship to Patient: _____ Ph (____) _____-_____

Name: _____ Relationship to Patient: _____ Ph (____) _____-_____

Parent/Guardian Signature: _____ DATE: _____/_____/_____

PATIENT RELEASE

I, _____(Patient/Guarantor name), hereby authorize Life In Motion Physical and Hand Therapy and its employees to release any or all of my patient health information including super confidential information to the person(s) listed below: *(EXAMPLE: A spouse or relative may be involved in billing and insurance inquiries).*

Name: _____ Relationship to Patient: _____ Ph (____) _____-_____

Name: _____ Relationship to Patient: _____ Ph (____) _____-_____

Name: _____ Relationship to Patient: _____ Ph (____) _____-_____

Patient/Guarantor Name: _____ DATE: _____/_____/____

Patient/Guarantor Signature _____

Workers Compensation Only

EMPLOYER INFORMATION

Job title: _____

Employer's Name: _____

Employer's Phone #: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

ADJUSTER / NURSE CASE MANAGER INFORMATION

Adjuster's Name: _____ NCM's Name: _____

Adjuster's Phone #: _____ NCM's Phone #: _____

Adjuster's Fax #: _____ NCM's Fax #: _____

PRIVACY NOTICE

In accordance with Health Insurance Portability and Accountability Act, patients of Life In Motion are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. A patient's Protected Health Information ("PHI") may only be released as authorized by this law. Life In Motion Physical and Hand Therapy will strive to ensure that patient information is used only for purposes authorized by the patient, including but not limited to patient treatment and payment operations, lawful subpoenas, and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Polices.

Additionally, upon providing reasonable advance notice, patients have a right to review their medical records and furnish comments to their recorders during normal business hours. In addition, patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

Moreover, patients have the right:

- To be informed of any breach of their unprotected PHI;
- To have marketing communications made to them only if authorized by the patient; and
- To decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim.

If you have any concerns, please contact Life In Motion Physical and Hand Therapy at (727) 369-6355.

Patient/Guarantor Name: _____ DATE: _____/_____/____

Patient/Guarantor Signature (if applicable) _____

DME CLAUSE

The products and/or services provided to you by Life In Motion Physical & Hand Therapy are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request, we will furnish you a written copy of the standards.

GENERAL ACKNOWLEDGEMENT

I acknowledge that I have read and understand all information contained in these forms. All information that I have supplied is accurate and complete to the best of my knowledge.

Patient/Guarantor Name: _____ DATE: _____/_____/____

Patient/Guarantor Signature (if applicable) _____