The Movement Therapy Institute
PHYSICAL THERAPY + PERFORMANCE

Patient Information

Please Print
Date: _____

Patient Name: _____

Parent/Guardian Name: _____ Age: _____

Date of Birth: _____

Address: _____ City:_____

State:_____ Zip: _____ Other Address: _____

City: _____ State:_____ Zip: _____

Home Phone #: (_____)_____

Cell Phone #: (_____)_____

Work #: (_____)_____

Most likely reached at: _____

Emergency Contact Name:_____
Relation: _____

Contact Address and
Phone:_____

Signature_____Date_____

drlatinofeliz@themovementtherapyinstitute.com Phone (305) 788-9532 Fax (954) 951-1341

The Movement Therapy Institute

Medical History/Health Questionnaire

1) Age: _____
2) Sex: _____
3) Family Hx of heart disease: YES_____ NO _____
4) Are you currently taking any medication or supplements? If yes, please explain_____
5) Are you pregnant? YES_____ NO_____
6) Have you recently given birth?If yes,when?_____
7) Have you ever had any injury or surgery to the following body parts? If yes, please explain.

Knees? YES_____ NO_____
Lower Back? YES_____ NO_____
Neck/shoulders? YES_____ NO_____
Hip/Pelvis? YES_____ NO_____
Foot/ankle? YES_____ NO_____
Other areas? YES_____ NO_____

Please circle any of the following conditions that you currently have:

Headaches	High/ low blood pressure	Major Accident
Varicose Veins	Blood Clots	Arthritis or tendonitis
TMJ	Abnormal Skin Condition	Heart/ Circulation Problem
Surgery	Neck/ Back Injuries	Diabetes
Fibromyalgia	Numbness/Tingling	Sprains or Strains
Fractures	Cancer	OTHER

Allergies/Medication: _____ Other: _____

Signature_____ Date _____

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History of Current Episode

Name: _____ Age: _____

Nature of Problem/Reason for Visit:

_____

Date of Onset: _____

Date of Current Surgery (if applicable):_____

Mechanism of Onset:

_____

Is this episode due to an Automobile Accident? _____ Work-Related Injury? _____

Current Pain Level Please circle: 0 1 2 3 4 5 6 7 8 9 10
(no pain) (ER)

Where did the pain start? _____

Where did pain spread? _____

Does pain prevent you from sleeping/awaken you?

_____

Do you have any numbness/tingling?

_____

Do you have difficulty sitting/standing/walking?

_____

Is your pain better/worse/same throughout the day?

Morning: _____ Mid-Day: _____ Night: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Have you previously received physical therapy in the current calendar year? Yes _____ No _____

If yes, approximately how long? _____

Is there litigation associated with this episode? Yes _____ No _____

Attorney: _____ Phone/Fax: _____

Signature_____ Date _____

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The Movement Therapy Institute

Authorization/Consent/Financial Policy

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

The Movement Therapy Institute is hereby authorized to disclose all or any part of the medical record of the patient named in the registration as per patient request. The authorization is effective for three years from the date of service and may be revoked with written notification

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby consents to any physical therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of The Movement Therapy Institute as to the results of any treatment given or performed.

TREATMENT RATES

Our practice is committed to providing the best treatment for our patients and we charge a non-negotiable flat fee for services rendered. You are responsible for payment. By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered.

SCHEDULING AND MISSED APPOINTMENTS

It is the patient's responsibility to make and confirm their appointments (date and time). We are unable to guarantee standing appointments but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment, we ask that you call 24 hours in advance to let us know. By calling us, you will allow us to make the appropriate changes to the schedule.

A $60 cancellation fee will be charged for missed appointments without 24 hour notice.

MEDICAL EMERGENCIES

It is our policy to call 911 in case of medical emergencies. I certify that I have read and understand fully the above information above.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Parent or Guardian Date

Patient Name: _____

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HIPAA/Authorization and Releases

Patient Health Information and Privacy Policy Authorization and Releases

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's right concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care.

2. The patient has the right to examine and obtain a copy of their health records at ant rime and request corrections. The patient may request to know what disclosures have been made, and submit in writing ant further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.

3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.

4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.

5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

INITIAL _____

Signature: _____ Date: _____

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