BACK TO MOTION
PHYSICAL THERAPY

616 Washington St.
No. 100
Denver, CO 80203
Phone 303.832.5577
Fax 303.996.0390

WELCOME TO BACK TO MOTION PHYSICAL THERAPY

Keeping YOU in Motion for Life - Thank You for Choosing Us!

What to expect at Back to Motion Physical Therapy:

- ✓ You can expect your clinician to listen to you and your concerns. We will use evidence based practice techniques to help relieve your symptoms.
- ✓ At your first visit, we will collect a history of your present concerns and physical condition. You will be evaluated by a physical therapist and receive treatment. Plan on an hour for this first visit.
- ✓ We will collect your insurance information and initiate a benefits check. Please bring you insurance card so we are able to make a copy of it.
- ✓ We will ask you to change into shorts and/or a top; they are provided on site, or if you prefer you can bring your own.
- ✓ Each treatment, you will be seen by a licensed professional for a one-to-one treatment; most treatments are between 30 – 45 minutes.
- ✓ Each treatment, expect Back to Motion's TOUCH care!
- ✓ Treatments are provided in a private treatment room; some exercises may be performed in an exercise area.

Other Back to Motion Physical Therapy Services:

- ✓ We offer Trigger Point Dry Needling (TDN). TDN is a procedure during which the therapist uses an acupuncture needle inserted into the muscle spasm to assist in decreasing muscle spasm and pain. We are often able to enhance the results of our deep massage techniques using TDN. Ask your therapist today.
- ✓ Running evaluations and orthotic prescription. Do you run or know someone who does? Our therapists can evaluate your running pattern and help identify any dysfunction or altered running pattern and prescribe exercise, stretching, or further treatment to help you maintain function.
- ✓ Experience what it is like to walk 50 pounds lighter than you are – **try the AlterG treadmill**! Using differential air pressure the AlterG treadmill can alleviate stress on joints in your lower back and legs allowing you to continue rehabilitation and exercise with less pain and discomfort. Ask for a free 10 minute trial when you get to the office.

Physical Therapy Equipment Available for Purchase

Weights & Exercise Bands	Exercise Balls	Mobilization Wedges
Cervical Pillows	The Stick (myofascial release)	The Foot Wheel
	Fitted Orthotics	

Please note:

- ✓ Co-payments or cash payments for treatment are due at the time of service.
- ✓ Our clinicians are very busy and in high demand. We do charge for cancellations not received at least 24 hours in advance and for "no show" appointments. Thank you for your consideration of our time.
- ✓ You are responsible to provide accurate information to Back to Motion regarding insurance and Worker's Compensation information. Back to Motion will not be responsible for re-billing insurance if inaccurate information has been provided or if you fail to provide updated insurance information.

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ADMINISTRATIVE USE ONLY – Please initial and date

_____ Pt Info _____ FOTO _____ Claim _____ Benefit Check _____Clinical Sub _____ Scanned

CLIENT REGISTRATION FORM – FOTO Supplement

First Name: Last Name:

(If Client is a minor) Parent's Name:

Address: Apt./Unit #:

City: State: Zip:

Primary Phone: ( ) H C W

Alternate Phone: ( ) H C W

DOB: SSN#:

Would you like to receive our e-newsletter? ☐ Yes ☐ No **Email address**: _____

Whom may we thank for referring you?

Emergency Contact:

Relationship to client: Phone:

Physician you want us to communicate with:

Physician Phone: MD Office Location:

Related to your health: **Is there a possibility you are pregnant?** (please circle) YES NO

Do you have any other health conditions we should be aware of? Please Explain: _____

_____

Method of Payment (Please circle): Insurance Medicare Worker's Comp Private Pay

Please fill out this section if you are using someone else's (parent or spouse) insurance

Name of Insured: Date of Birth:

SSN#: Relationship to Client:

Primary Phone: ( ) H C W

Please note: In the event of a change in payment method and/or insurance, you are required to notify Back to Motion immediately to avoid incurring additional financial responsibility on your part.

Please be sure to read the following statement: By signing this document, you are consenting to physical therapy treatment at Back to Motion Physical Therapy with the understanding that the goal of physical therapy is to improve overall function and movement. You must also understand that physical therapy is an inexact science and that in the course of treatment your condition should improve; however it may worsen, or you may not experience significant gains or a decrease in pain.

Client's/Guardian's Signature:_____ **Date:**_____

Client's/Guardian's Printed Name:_____

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RELEASE AND CONFIDENTIALITY AGREEMENT

I hereby authorize Back to Motion Physical Therapy, Inc. to release to my insurance company or its representatives, and other health care professionals working on my medical case, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I also authorize and request my insurance company to pay directly to the above named physical therapy clinic the amount due for services rendered. I understand that it is my responsibility to call my insurance company to verify coverage for physical therapy through my policy, and agree to pay any co-pays, deductibles, and any other portions that my insurance company will not pay. ** If I cancel my appointment with less than 24 hour notice I will be charged, and agree to pay, for the visit. **

I understand that I may receive a bill for services rendered, and that payment of said bill is expected by/on the due date. In the event payment is not received on time, my account will be subject to an interest charge of 1% per month. If no payment is made, my account will be placed with a collection agency for the amount due as well as collection fees.

I have read and fully understand Back to Motion's Notice of Information Practices. I understand that Back to Motion may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to designate individuals to whom my information can be released. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Back to Motion will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Back to Motion's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I also authorize Back to Motion to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

CONCERNS AND COMPLAINTS

If you are concerned that Back to Motion may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our privacy officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Back to Motion's health information practices or if you have a complaint, please contact Lorienne Fisher, Safety Officer; 616 Washington St No. 100, Denver, CO 80203; Phone 303-832-5577.

Print Name: _____ **Date:** _____

Signature of Patient or Patient Representative*: _____

*If Patient Representative, Legal documentation must be included to show authority to sign or receive information

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Back to Motion Payment Policy

1. Insurance. Back to Motion participates in many insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive at Back to Motion may not be covered or may be considered not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form and benefit verification form before seeing the physical therapist. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you and you will be responsible for payment in full of such billed charges.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and that you may be held responsible for attorney and collection fees. You may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within twenty-four (24) in advance of the scheduled appointment. These charges will be your responsibility and billed directly to you.

Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**