BACK TO MOTION PHYSICAL THERAPY

BTM: DENVER
600 Grant St. Ste 208
Denver, CO 80203
PHONE: 303.832.5577
Fax: 303.996.0390

BTM: WHEAT RIDGE
7821 W. 38th Ave. Ste 101
Wheat Ridge, CO 80033
PHONE: 303.955.8091
Fax: 303.573.2406

www.backtomotion.net info@backtomotion.net

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.
- ✓ We will collect your insurance information and initiate a benefits check. Please bring your insurance card so we can copy it for your file.
- ✓ Please wear comfortable clothing you can move freely in. We may 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 physical therapist for a one-to-one treatment; most treatments are between 30 – 45 minutes.
- ✓ Treatments are provided in a private treatment room; some exercises may be performed in an exercise area.
- ✓ Each treatment, expect Back to Motion's TOUCH care!

Other Back to Motion Physical Therapy Services:

- ✓ ***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:*** 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.
- ✓ ***Alter G Treadmill:*** 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.
- ✓ ***Telehealth Appointments:*** Many insurances cover telehealth appointments. In times of need or last minute issues, Back To Motion therapists offer the means to have a session remotely.

Please note:

- ✓ **Costs for treatment (amount towards deductible, coinsurance, co-payments as determined by your insurance plan or self-pay rates) are due at the time of service.**
- ✓ You are responsible for providing 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.
- ✓ ***Our clinicians are very busy and in high demand. There is a $45 charge for cancellations not received at least 24 hours in advance and a $60 charge for "no show" appointments. Thank you for your consideration of our time.***

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PATIENT REGISTRATION FORM

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

** Please note you will receive text reminders for your appointments. You may opt out at any time.*

Email Address: _____

** Please note that **billing invoices will be emailed to you from noreply@heno.io. Please add it to your email contact list.***

** Email reminders for your appointments are available. Please let staff know if you'd like to opt in at any time*

Emergency Contact: _____

Relationship to Patient: _____ Phone #: _____

Whom may we thank for referring you? _____

Claims Type: ☐ Commercial Insurance ☐ Medicare Advantage Plan ☐ Medicare ☐ Medicaid (State Plan)
☐ Worker's Comp ☐ Motor Vehicle – Own Ins ☐ Motor Vehicle – Lien Co Private/Self Pay

Name of Insurance(s): _____

** Please note: In the event of a change of insurance you are required to notify Back To Motion immediately for claims to be billed to the appropriate company and to avoid incurring additional financial responsibility on your part*

If the patient is NOT the primary insurance holder, please complete this section:

Name of Subscriber: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Cell Phone: _____ Home Phone: _____

Please read the following statement and sign below:

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 during the course of treatment your condition should improve; however, it may worsen, or you may not experience significant gains or a decrease in pain.

Patient Signature (Or patient representative): _____ Date: _____

Patient Printed Name (Or patient representative): _____

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

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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 Back To Motion will attempt to determine what the cost is per visit per my insurance plan, but 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, amounts towards deductibles, co-insurance and/or any other portions that my insurance company will not pay.***

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 restrictions 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; 600 Grant St. Ste. 208, Denver, CO 80203; Phone 303-832-5577.

By signing, I confirm that I have read and understand Back To Motion's Release and Confidentiality Agreement:

Patient's Signature (Or Patient Representative): _____ **Date:** _____

Patient's Printed Name (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 Policies

1. Insurance: Back to Motion participates in many insurance plans, including Medicare and Medicaid. 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. Proof of insurance: We strive to determine eligibility and benefits through insurance prior to patient appointments. We must obtain a copy of your driver's license and current valid insurance to further provide proof of insurance.

3. Co-payments, Deductibles, and Co-Insurance: All costs for treatment must be paid at the time of service. This arrangement is part of your contract with your insurance company and/or with Back To Motion PT. Failure on our part to collect copays, amounts towards deductible, or co-insurance for treatment can be considered fraud. Please help us in upholding the law by paying your cost at each visit.

4. Non-covered Services: Please be aware that some 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. Payment for these services is required in full at the time of visit.

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. TCPA (Telephone Consumer Protection Act) Prior Express Consent Clause: We want to stay in touch with you regarding your account. In order for us to service your account or to collect any amounts you may owe, you agree that we may contact you by telephone at any telephone number, including wireless telephone numbers that you have or may attain. We may also contact you by sending text messages to any telephone numbers that you have or may attain, or e-mail using any e-mail address owned by you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

8. Nonpayment: ***If your account is over 90 days past due, your account will be charged a 3% finance fee.*** You will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. **Collections:** Please be aware that if a past-due balance remains unpaid, and after multiple attempts to contact you, we may assess an $80 collections fee and refer your account to a collection agency. You may be held responsible for attorney and collection fees. You will be discharged from this practice.

8. Missed appointments: ***BTM policy is to charge $45 for appointments not canceled within twenty-four (24) in advance of the scheduled appointment, or $60 for failing to show to an appointment. These charges will be your responsibility and billed directly to you and payable prior to your next visit.*** Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment for 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.

By signing, I confirm that I have read and understand Back To Motion's Payment Policies:

Patient's Signature (Or Patient Representative): _____ **Date:** _____

Patient's Printed Name (Or Patient Representative): _____

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

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PATIENT MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

GENERAL MEDICAL INFORMATION

Referring Provider: _____ Physician Phone #: _____
Required for AARP HMO, Humana, and Workers Comp Patients

Clinic Name: _____ Clinic Location: _____

Primary Care Physician: _____ Physician Phone #: _____
Required for Medicare and Medicaid Patients

Clinic Name: _____ Clinic Location: _____

What *health conditions* do you have that we should be aware of? _____

_____

Have you had any major *surgeries*? ☐ *No* ☐ *Yes:* _____

Current Medications: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____
*Required for Medicare Patients: **You may provide a list to copy to your file***

Please Rate Your *Sleep Quality:* 1 2 3 4 5 6 7
Poor/Disrupted Sleep — Average Sleep — Restful/Sound Sleep

PHYSICAL THERAPY INFORMATION

What are we seeing you for today? _____

☐ *Right Side* ☐ *Left Side* ☐ *Both Sides* ☐ *Pre-Op?* ☐ *Post-Op?*

Date of Injury or when pain started: _____
Actual Date of Injury or Accident is required for Workers Comp and Motor Vehicle Claims

Have you experienced any dizziness or disorientation? ☐ No ☐ Yes

If so, does the body position change the intensity? ☐ No ☐ Yes _____

Severity of Pain: On a scale of 1-10 (low-high), describe when it is at its worst: ☐ When it is at its best: ☐

How long does the pain last? _____

Does the pain radiate or refer elsewhere? _____

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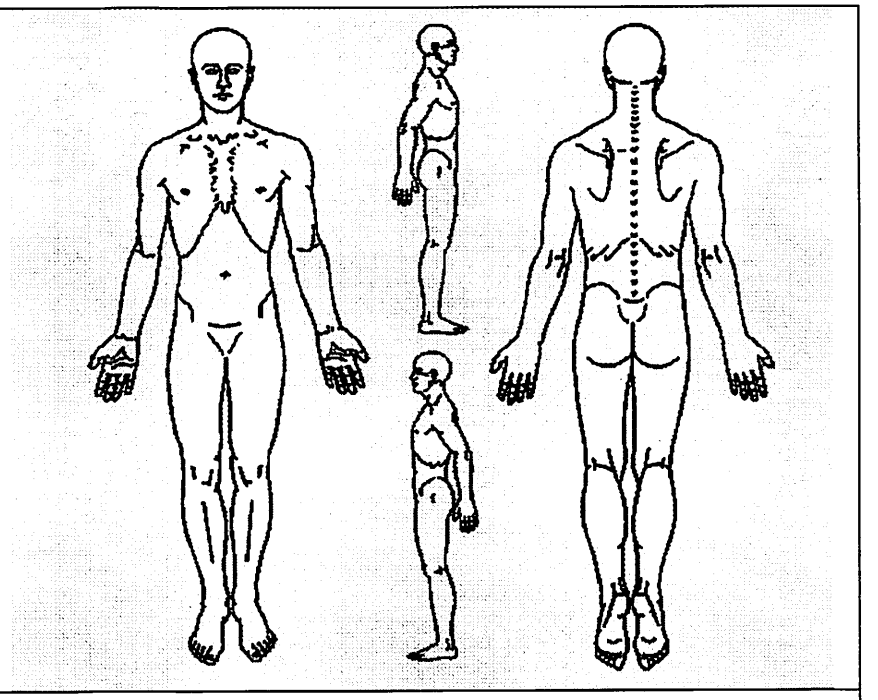
Quality of Symptoms: On the diagram, indicate where you are experiencing pain, or other symptoms, using the following codes:

A = Aches
B = Burning
D = Dull
N = Needles/Pins
P = Piercing
S = Stabbing
T = Tingling/Numbness
Th = Throbbing
O = Other



What Makes Symptoms Worse?
☐ Bending ☐ Lifting ☐ Squatting ☐ Twisting ☐ Pushing
☐ Standing ☐ Movement ☐ Walking ☐ Exercise ☐ Lying in bed
☐ Stairs ☐ Sneezing ☐ Coughing ☐ Other: _____

What Makes Symptoms Better?
☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Movement
☐ Other: _____

Please list 3 movements or activities you hope will improve with physical therapy.
Rate your current ability on a scale of 0 to 10, with 0 being completely unable and 10 being fully able:

1. _____ ____/ 10
2. _____ ____/ 10
3. _____ ____/ 10

Patient Signature: _____ Date: _____

Notice of Privacy Practices for Protected Health Information Back To Motion Physical Therapy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective Date: December 2011; Revised September 2023

The practice of Back To Motion Physical Therapy is required by applicable federal and state laws to maintain the privacy of your health information. Protected Health Information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclosure of PHI for the purposes of treatment, payment, and health care operations without your written authorization.

Examples Of Uses of Your Health Information For Treatment Purposes Are:

- Our providers obtain treatment information about you and record it in a health record.
- During the course of your treatment, if the PT determines he/she will need to consult with a specialist in another area, he/she will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition, or to remind you of medical appointments.

Example Of Uses Of Your Health Information For Payment Purposes:

- We submit requests for payment to your health insurance company.
- The health insurance company requests information from us regarding medical care provided to you. We will provide this information to them.

Example Of A Use Of Your Information For Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities such as quality assessment activities, to review employee activities, or to assist in the training of students. We may share information about you with our business associates, who perform these functions on our behalf, as necessary to obtain these services.

Other Examples:

- We may use or disclose you PHI to provide you with information about the treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may also use or disclose your PHI for activities such as sending you a newsletter about our practice and the services we offer. You may contact us to request that these materials not be sent to you.

Other uses and disclosures of your PHI will only be made with your authorization, unless otherwise permitted or required by law, as described below.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in them, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information. We are not required to grant the request, but we will comply with any request that we agree to grant;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Heath Information ("the Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record. You may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that either was not created by us (unless the person or entity that created the information is no longer available to make the amendment), is not part of the health information kept by the office, is not part of the information that you would be permitted to inspect and copy, or is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Restrict information going to your health plan about an item or service for which you pay the practice out of pocket and in full for the item or service;
- Obtain an accounting of disclosures of your health information as required to be maintained by law. An accounting will not include uses and disclosures a of information for treatment, payment, or operations; disclosures or uses made to you or made at your request uses or disclosures made pursuant to an authorization signed by you uses or disclosures made in a facility directory or to family members or friends relevant to that persons involvement in your care or in payment of such care, or uses or disclosures to notify family or others responsible for your care of your location, condition or your death; and
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

If you would like to exercise any of the above rights, please contact the Privacy Officer at (303) 832-5577 during regular business hours, or in writing. The Privacy Officer will inform you of the steps needed to exercise your rights under HIPAA.

Our Responsibilities: The office is required to

- Maintain the privacy of your health information as required by law;
- Provided you with a notice ("Notice") as to our duties and privacy practices regarding the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you and not disclose PHI to your health plan if you request that we do not, and pay for the item/service out-of-pocket and in full. You must request this Patient Right in writing.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy, visiting our website or by visiting our office and picking up a copy.

To Request Information or File a Complaint:

If you have questions, would like additional information, or would like to report a problem regarding the handling of your information, you may contact the Privacy Officer. If you believe you privacy rights have been violated, you may file a complaint by delivering it in writing to the practice's Privacy Officer. You may also file a complaint with the Secretary of Health and Human Services, Office for Civil Rights (OCR). The address for this office is: Centralized Case Management Operations - U.S. Department of Health and Human Services – 200 Independence Avenue, S.W. – Room 509F HHH Bldg. - Washington, D.C. 20201. Information regarding the steps to file a complaint with the OCR can also be found at www.hhs.gov/hipaa/filing-a-complaint

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Uses and Disclosures of your PHI

- **Communication With Family:** Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify health information relevant to that person's involvement in your care or in payment such care if you do not object, or in an emergency.
- **Notification:** Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
- **Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Disaster Relief:** We may use and disclose your protected health information to assist in disaster relief efforts.
- **Food and Drug Administration (FDA):** We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable production recalls, repairs, or replacements.
- **Workers' Compensation:** If you are seeking compensation through Workers' Compensation, we may disclose your PHI to the extent necessary to with laws relating to Workers' Compensation.
- **Public Health:** As authorized by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.
- **Abuse & Neglect:** We may disclose your PHI to public authorities as required by law to report abuse or neglect.
- **Employers:** We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.
- **Enforcement:** We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.
- **Health Oversight:** Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities
- **Judicial/Administrative Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.
- **Serious Threat:** To avert a serious threat to health or safety, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- **For Specialized Governmental Functions:** We may disclose your PHI from specialized government functions as authorized by law such as to Armed Forces personnel, for national security purpose, or to public assistance program personnel.
- **Other Uses:** Other uses and disclosures, besides those identified in the Notice, will be made only as otherwise required by law or with your written authorization. You may revoke any authorization at any time, as previously provided in this Notice under "Your Health Information Rights."
- **Website:** You are able to access this Notice electronically on our website: www.backtomotion.net