



135 E St Charles Rd Suite G
Carol Stream, IL 60188
Ph. (630) 588 – 0600
Fax (630) 588 – 0606
Email healthymotion@mac.com

Today's Date: _____

Physical Therapy Intake Form

CONFIDENTIAL CLIENT INFORMATION

Name: _____	Day Phone: _____			
Address: _____	Eve. Phone: _____			
City: _____ ST: _____ Zip: _____	Cell Phone: _____			
Email: _____ <i>We do NOT share our email list. We use email to confirm appts. and to notify you of special promotions and events.</i>				
Date of Birth: _____	Social Security Number: _____	M / F (pls circle)		
Primary Insurance Provider: _____	ID # _____	Group # _____		
Name of Ins. Holder: _____	DOB of Ins. Holder: _____	SSN of Ins holder: _____		
Employer of Ins. Holder: _____				
Secondary Insurance Provider: _____	ID # _____	Group # _____		
Name of Sec. Ins holder: _____	DOB of Sec. Ins. Holder: _____	SSN of Sec.: _____		
We will call or email the day before your appointment as a complimentary reminder. How would you like to be reminded?				
Email _____	Day Phone _____	Eve. Phone _____	Cell phone: _____	Please do not remind me _____

How were you referred to us?	
____ Friends/Family Who? _____	Ad or News article. Where? _____
____ Internet: ____ Our web site ____ Facebook ____ Web search	Phone book: ____ White pgs. ____ Yellow pgs. _____
____ Other? _____	
THANK YOU!	

Occupation: _____ Referring Physician _____ Office Location _____

Is your current injury the result of an accident? Y / N If yes, please describe:

Is your current injury work related? Y / N If yes, please describe:

How many hours a day do you : sit ____ walk ____ stand ____ lift ____ ?

What seems to make your problem worse? _____

What seems to make it better? _____

Please list the dates and results of any X-rays: _____

MRI's: _____

Do you exercise regularly? Y / N If yes, what sort of activity and how often?

Please circle/or list all medical conditions that you have or have had:

Cancer Pacemaker High Blood Pressure Diabetes Currently pregnant or breastfeeding heart disease

Please list all medications you are currently taking: _____

Financial Information:

Healthymotion Inc. will electronically bill your insurance company for services rendered. Please read and sign the following to allow us to provide you with this service.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Healthymotion, Inc. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the clinic to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such clinic any and all plan documents, insurance policy and/or settlement information upon written request from such clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such therapist and clinic in any attempts by such clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such clinic against such insurers and/or employee health care plan in my name but at such clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. The above information is correct and I consent for physical therapy treatment by Healthymotion, Inc. I also have been offered a copy of the HIPAA policy.

Client Signature

Date