BIOMOTION
PHYSICAL THERAPY, INC.
Specializing in Orthopedic & Sports Injuries

Dave Faciana, DPT & Associates

move better. feel better. perform better

Since 1996

Welcome to Our Clinic

On behalf of all staff, we would like to welcome you to our clinic. We are pleased to have the opportunity to help you with your physiotherapy care. Our goal is to provide physiotherapy treatments of the highest quality and most accurate scientific evidence available, in a professional and caring manner. We are committed to helping you achieve your rehabilitation goals as we strive to meet our motto, "It is our goal to provide exceptional care and service."

We would like to review some of the office's policies with you. We believe this will improve your understanding of how our office works and help you receive the maximum benefit of the physiotherapy treatments you will receive.

Our office policies are as follows:

• If you arrive after your appointment time, we will do our best to ensure you receive the maximum benefit from your program. Understand that our commitment to exceptional service extends to all our customers.

• It is important for the recovery process that you meet all your prescribed appointments. As a courtesy to others, should you need to cancel or reschedule your appointment, please give a 24-hour notice.

• We will call and verify your insurance benefits as a courtesy to you. However, you should consider the limitations or stipulations that your insurance may have regarding physiotherapy care. We are not responsible for any inaccurate information from the insurance company regarding your benefits.

• We will provide your doctor with a progress report at the time of your follow-up with him / her. Notify us of any changes in the appointment so that we can prepare accordingly.

Whether you're looking to resume pain-free activities at home, work or play, we are sure that your experience in our office will be valuable to help you achieve your goals.

Patient Information

Please Print Clearly

Patients Name:_____ Nickname:_____

Birthdate: / / Age: Gender: ☐ Male or ☐ Female

Address: City: State: Zip Code:

Home Phone: Cell Phone:

E-Mail Address:

Employer: Occupation: Phone Number:

Address: City: State: Zip Code:

Insured Name: Birthdate: / / Relationship:

Phone Number: Employer:

Emergency Contact Name: Relationship: Phone Number:

Would you like appointment reminders (choose one): Call?☐ Text?☐ Email?☐ None☐

Please answer all questions. If question does not apply to your injury, please write N/A for not applicable.

Date of injury: / / Is injury work related? ☐ Yes or ☐ No

If work related, who was the employer at the time of the injury?

Is the injury related to an accident? Auto ☐ Other:

Are you involved in a lawsuit as a result of this injury: ☐ Yes or ☐ No

Name of physician or person who referred you to this office :

Billing Information

Primary Insurance Name: Cardholder Name:

Insurance Claims Address:

ID#: Group#: Policy Name:

Secondary Insurance Name: Cardholder Name:

Insurance Claims Address:

ID#: Group#: Policy Name:

I hereby irrevocably authorize payment of medical services rendered to me or my dependents directly to Biomotion Physical Therapy, Inc. I also authorize Biomotion Physical Therapy to provide my insurance with complete information about the treatment provided to me or my dependents. A photocopy of it will be valid. I also understand that my insurance is billed as a courtesy and that I am responsible for all charges that my insurance does not pay within 8 (eight) weeks after the billing date. There will be a financial charge of 1 1/2% for all unpaid balances. In addition, I understand that any supply given to me or my dependents may not be covered by my insurance; For this reason, it is usual to pick up supplies at the time of service. As a courtesy to other patients please give a 24-hour notice should you need to cancel or reschedule your appointment.

Signature of Patient or Responsible Party: Date: / /

Patient Questionnaire

Patient Name: _____ Age: _____ Date: ____/____/____

Medical History:

Do you now have/ or had any of the following:

Diabetes	Yes☐ No☐	Sensitive to Heat/ Ice	Yes☐ No☐
High Blood Pressure	Yes☐ No☐	Pregnant (Currently)	Yes☐ No☐
Heart Disease	Yes☐ No☐	Other Allergies	Yes☐ No☐
Heart Attack	Yes☐ No☐	Previous Surgeries	Yes☐ No☐
Pacemaker	Yes☐ No☐	Hernia (Ventral, Inguinal, etc.)	Yes☐ No☐
Headaches	Yes☐ No☐	Seizures	Yes☐ No☐
Kidney Problems	Yes☐ No☐	Metal Implants	Yes☐ No☐
Nervous Disorders	Yes☐ No☐	Cancer	Yes☐ No☐

If yes on any of the above, please explain and give approximate dates: _____

_____

Are you presently taking any medications? Yes☐ No☐ If yes, list what medications and for what condition:

_____

_____

Reason for physical therapy (include dates and circumstances): _____

_____

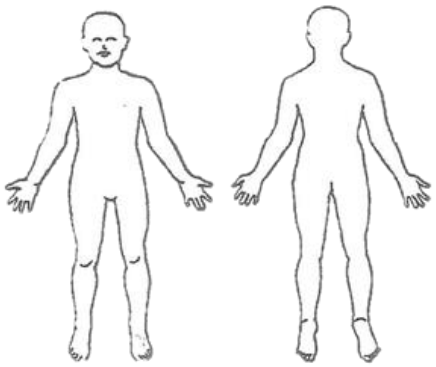
Pain Description (circle all that apply): ☐ Burning ☐ Sharp ☐ Achy/ Dull ☐ Throbbing ☐ Shooting
☐ Numbness/Tingling ☐ Constant ☐ Intermittent ☐ Worse in AM ☐ Worse in PM

Pain Scale (1-10): Current: ____ Best: ____ Worst: ____

Do you have any other problems or concerns we should be made aware of?_____

_____

Please shade in areas of concern on the diagram below:



Patient or Guardian Signature: _____ Date: ____/____/____

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Patient Name: _____

Consent for care and treatment

I, the undersigned, accept and give my consent for Biomotion Physical Therapy to provide the care and treatment deemed necessary and appropriate to treat my condition.

Authorization for signature on file and information disclosure

I, the undersigned, authorize the Biomotion Physical Therapy office to place my name on each and every claim or document related to each and every health benefit owed to me. I authorize the release of any information related to my health care claims. A photocopy of this authorization will be valid as original.

Authorization for benefit allocation

I, the undersigned, assign all medical benefits, to which I am entitled, to the Biomotion Physical Therapy office, and I will be financially responsible for any unpaid balance. In the event that the payment is made directly to me for the services provided by this office, I acknowledge the obligation to send the payment immediately to this office. I hereby authorize and instruct my insurance company to pay by check and send it directly to:

Biomotion Physical Therapy
865 Patriot Drive, Ste. 202
Moorpark, CA 93021

Financial responsibility

I understand and agree that if legal action is necessary, I am responsible for all costs of collecting the money owed, including court costs, collection agency fees and attorney fees, in addition to the outstanding balance of my account. In addition, I understand that balances of more than 60 days will be subject to a 1.5% financial charge, for which I am personally responsible. Biomotion Physical Therapy is not responsible for any inaccurate information given from the insurance company regarding my benefits.

Cancellation policy

A specific time is reserved for you when you schedule an appointment. If you cannot attend your scheduled appointment, let us know at least 24 hours in advance so that we can reschedule your appointment and offer the reserved time to another patient.

I have read and fully understand all the above information and hereby agree to comply as described above.

Patient or Guardian Signature_____Date____/_____/_____