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

Legal Name(Last):_____(First)_____(MI)___
Preferred Name:_____
DOB:_____/_____/_____Age:_____Gender:___M___F__
Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Work Phone:_____
Cell Phone:_____Reminder texts?__Y / N_____
E-Mail Address:_____Reminder emails?__Y/ N_____
Employer:_____Occupation:_____Phone#:_____
Address:_____City:_____State:_____Zip Code:_____

Emergency Contact:_____Relationship:_____Phone #:_____

Referring Physician Information:

Physician's Name:_____Phone #:_____
Physician's Address_____Fax #:_____
Prescription Date:_____/_____/_____
If not referred to by a physician, how did you hear about us?_____

Billing Information **(ignore if photocopy of card was made)**

Primary Insurance Name:_____Insured Name:_____
Policy Holder's Name:_____DOB:_____Relationship to patient:_____
Insurance Claims Address:_____
ID#:_____Group#:_____Policy Name:_____
Secondary Insurance Name:_____Insured Name:_____
Policy Holder's Name:_____DOB:_____Relationship to patient:_____
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:_____ DOB:_____

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:

_____

_____

All questions MUST be answered.

Date of injury or initial occurrence:_____/_____/_____ Date of Surgery:___/___/___

Injury Type: Work / Auto / Other or None

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

Adjustor's name: Phone #:_____

If you chose other, please explain:_____

Are you involved in a lawsuit as a result of this injury:_____Y / N_____

Describe the possible cause of injury, your symptoms, or areas of concern.

_____

_____

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

Other:_____

What causes pain or symptoms, if any?_____

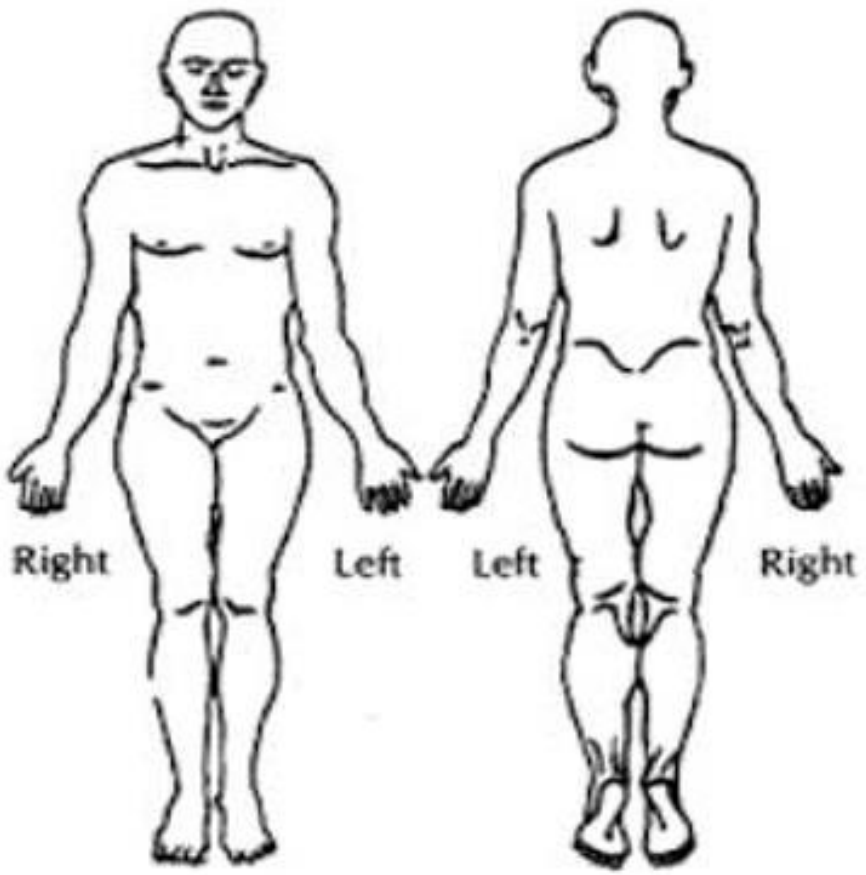
What alleviates pain or symptoms, if any? _____

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

_____

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

Please shade in areas of concern below:



Pain Scale (0= no pain, 10= extreme pain):

Currently:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

Patient or Guardian Signature: _____ Date: / /

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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 by 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 Name (printed): _____

Patient or Guardian Signature_____Date___/_____/_____