mti physical therapy
PROVIDING ONE-TO-ONE CARE

PATIENT INFORMATION

LEGAL NAME .....

PREFERRED NAME .....

ADDRESS .....

CITY/STATE..... ZIP .....

GENDER: ☐ Female ☐ Male ☐ Transgender
☐ Gender Non-Conforming/Non-Binary ☐ Additional .....

PRONOUNS: ☐ They/Them ☐ She/Her ☐ He/Him

SEX (as reflected on insurance policy): ☐ Female ☐ Male

DATE OF BIRTH .....

Please select 2 preferred contact methods for reminders:

☐ CELL PHONE .....

☐ EMAIL.....

EMERG. CONTACT .....

RELATION TO YOU ..... PHONE #.....

BODY PART AFFECTED .....

HAVE YOU HAD PT THIS YEAR? .....

DATE OF ONSET/INJURY.....

IS INJURY FROM: ☐ Auto ☐ Work ☐ Other

CARETAKER/INTERPRETER .....

REFERRING DOCTOR .....

DR. PHONE NUMBER.....

PRIMARY CARE DR. .....

DR. PHONE NUMBER .....

HOW DID YOU HEAR ABOUT US?

☐ Healthcare Provider.....

☐ Family/Friend.....

☐ Internet Search..... ☐ Social Media.....

☐ Event ..... ☐ Other .....

INSURANCE POLICY INFORMATION

PRIMARY HEALTH INSURANCE

INSURANCE COMPANY.....

IDENTIFICATION NUMBER.....

GROUP NUMBER .....

PRIMARY INSURED NAME .....

RELATION TO PATIENT .....

PRIMARY INSURED DATE OF BIRTH .....

☐ Insurance Card Provided?

SECONDARY HEALTH INSURANCE

INSURANCE COMPANY.....

IDENTIFICATION NUMBER.....

GROUP NUMBER .....

PRIMARY INSURED NAME .....

RELATION TO PATIENT .....

PRIMARY INSURED DATE OF BIRTH .....

☐ Insurance Card Provided?

If treatment relates to an Auto or Work related injury, please provide the information below.

YOUR AUTO/L&I INFORMATION

INSURANCE COMPANY.....

CLAIM NUMBER .....

ADDRESS .....

CITY/STATE..... ZIP .....

ADJUSTER'S NAME .....

PHONE NUMBER.....

ATTORNEY

NAME .....

FIRM .....

PHONE NUMBER .....

PATIENT AGREEMENT-PLEASE READ CAREFULLY

I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize the provider to release any information to referring/consulting physicians or other health care providers that may be necessary to facilitate care. I hereby authorize my insurance benefits to be paid directly to Manual Therapy International (dba MTI Physical Therapy). I certify that a copy of this agreement shall be valid as the original.

Patient or Legal Guardian Signature

Date

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FINANCIAL POLICY

Thank you for choosing MTI Physical Therapy. The following is a statement of our financial policy that outlines patient and practice financial responsibilities. Please feel free to contact the billing office at billing@mtipt.com if you have any questions.

Claims will be filed with your insurance company. By signing below you hereby authorize your insurance benefits to be paid directly to MTI Physical Therapy. You will be responsible at the time of service for all co-pays, co-insurance, deductibles, and services not covered by your plan. Financial responsibility for services rendered rests with you regardless of any insurance coverage.

CHANGE OF INSURANCE

It is your responsibility to provide accurate and up-to-date insurance information and to alert MTI Physical Therapy of any insurance changes during the course of your treatment. Claims denied due to "untimely billing" will be your responsibility if we were not initially provided with the correct billing information which resulted in late submission.

INSURANCE COVERAGE RESPONSIBILITY

You are responsible for obtaining and maintaining valid referrals and/or prescriptions for any and all covered services. It is also your responsibility to know the coverage, limitations, and restrictions of your insurance plan regarding physical therapy. Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim. We file insurance as a courtesy. Insurance follow-up is your responsibility, as is financially responsible for all claims denied by insurance. If your insurance company does not cover physical therapy and you choose to pay out of pocket for treatment, your balance is due at the time of your appointment.

STATEMENTS

Regardless of any claims pending, if there is an open balance, a statement will be sent to you once a month. Balances are due within 30 days.

COLLECTIONS AND NSF CHECKS

Delinquent accounts consist of balances left unpaid for 120 days. In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and a $25.00 collection fee. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees, and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

SERVICE AGREEMENT

I hereby give my consent for MTI Physical Therapy to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. With this consent, MTI Physical Therapy may call my home, mobile phone, or other alternative location, and leave a message on voicemail or in-person in reference to any items that assist MTI Physical Therapy in carrying out treatment, payment collection, and other healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

MTI Physical Therapy may mail to my home, or other alternative location, or email to the specified email address, any items that assist the practice in carrying out treatment, payment collection, and healthcare operations, such as patient statements. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive treatment services from MTI Physical Therapy. I agree to be fully responsible for any and all charges for services rendered and not paid by my insurance plan.

_____ _____

Signature of Patient or Legal Guardian ***Date***

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CANCELLATION AND NO-SHOW POLICY

We are committed to providing you with the highest quality of care and ask that you partner with us by being an active participant in your recovery process. Complying with your plan of care, including attending all scheduled appointments and following your home exercise program, is essential to achieving the best possible outcome from physical therapy. Our Cancellation and No-Show policy is in place to reinforce the need for consistent care in order for your condition to improve.

- **Appointments not kept or canceled with less than 24 hours notice prior to the scheduled appointment time will incur a $95 cancellation fee**
- **If you are more than 15 minutes late to your appointment, your appointment will be canceled and you will incur a $95 cancellation fee**
- **If you miss two appointments without proper notice, all future appointments may be canceled**

Appointment reminders are sent as a courtesy. It is your responsibility to know when your appointments are. Cancellations received with more than 24 hours notice from your scheduled appointment time will not be charged. You are expected to leave a time stamped voicemail or email to cancel if you are unable to speak to someone directly on the phone. Cancellation fees cannot be billed to your insurance company and are your responsibility. Missed appointment fees must be paid at the next scheduled appointment.

By signing below, you acknowledge that you have read our policy and understand that your commitment to complying with your plan of care is essential to a successful physical therapy outcome.

_____ _____

Signature of Patient or Legal Guardian ***Date***

PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information (PHI) for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. If you do not want us to share your PHI for this purpose, you can make this request in writing without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

_____ _____

Signature of Patient or Legal Guardian ***Date***

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PATIENT HEALTH QUESTIONNAIRE

NAME ..... WEIGHT ..... HEIGHT ..... AGE ..... SEX .....

Check all boxes that apply.

Have you or any immediate family member ever been told you have:

	You	Family
Cancer	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Angina/Chest Pain	☐	☐
Stroke	☐	☐
Arthritis	☐	☐

Do you have a history of:

- ☐ Shortness of Breath
- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Kidney Disease/Stones
- ☐ Polio
- ☐ Emphysema
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Ulcers

Check all boxes that apply.

With current problem do you experience:

- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Unexplained Weight Change
- ☐ Numbness or Tingling
- ☐ Bowel or Bladder Changes
- ☐ Dizziness
- ☐ Night Pain
- ☐ Headaches
- ☐ Muscular Weakness
- ☐ Surgery

For this problem have you received treatment from:

- ☐ Orthopedist
- ☐ Physiatrist
- ☐ Neurosurgeon
- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Osteopath
- ☐ Acupuncturist
- ☐ Psychologist
- ☐ Other Physical Therapist
- ☐ Other .....

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections?

☐ No ☐ Yes
Describe: .....

How often do you feel stress is a significant factor in your life?

☐ Never ☐ Seldom ☐ Regularly ☐ Always

Date of last complete physical examination? .....

Do you smoke?

☐ No ☐ Yes How many packs? .....
For how long? .....

Do you drink alcohol?

☐ No ☐ Yes # of drinks per week? .....

Do you use caffeine?

☐ No ☐ Yes # of cups per day? .....

List regular exercise/activity:

.....
.....
.....
.....

Other comments:

.....
.....
.....
.....

[see next page]

Name: _____ Date: _____

Modified STarT Back Screening Tool (mSBT)

Thinking about the **last 2 weeks** tick your response to the following questions:	Disagree 0	Agree 1
1. My current pain has spread to other body regions at some time in the last 2 weeks	☐	☐
2. I have had pain in other body regions other than my primary current pain	☐	☐
3. I have only walked short distances because of my current pain	☐	☐
4. In the last 2 weeks, I have dressed more slowly than usual because of current pain	☐	☐
5. I can't do all the things normal people do because it's too easy for me to get injured	☐	☐
6. I worry too much over something that really doesn't matter	☐	☐
7. I feel terrible, and I think it's never going to get any better	☐	☐
8. Little interest or pleasure in doing things	☐	☐

9. Overall, how bothersome has your current pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

Pain/Symptom Ratings and Descriptions

Please Rate your primary pain [P1]

0 = None 5 = Moderate 10 = Extreme

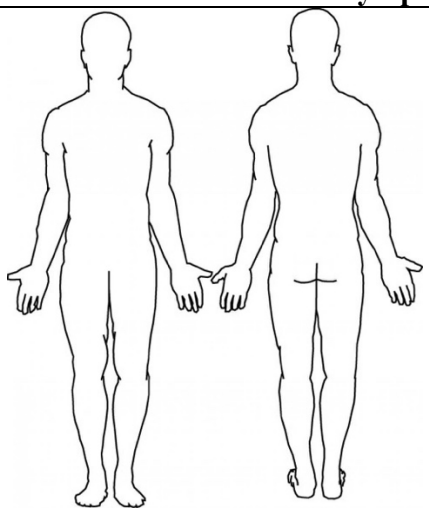
	NT	0	1	2	3	4	5	6	7	8	9	10
At worst:	○	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○	○
At best:	○	○	○	○	○	○	○	○	○	○	○	○

Please Rate if you have a 2nd Region of Pain [P2]

0 = None 5 = Moderate 10 = Extreme

	NT	0	1	2	3	4	5	6	7	8	9	10
At worst:	○	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○	○
At best:	○	○	○	○	○	○	○	○	○	○	○	○

Please Draw the Location of Symptoms



Medication List

MTI Physical Therapy

Patient Name: _____ Therapist: _____

Date of Birth: _____ Date: _____

Allergies:

MEDICATION brand, generic name, dose	Dose	When Taken	STARTED taking on:	REASON FOR TAKING	WHO Told Me To Take This ?