AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by Motivate, employees or designees and authorize medical services, diagnostic procedures as deemed necessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care or treatment, which may be given to me.

NOTICE OF PRIVACY PRACTICES-NPP

Notice of Privacy Practices provides detailed information about how the practice may disclose my confidential information. Statement of Privacy Practices will be included in my Patient Take Home Folder. I understand I may request Statement prior to attending my appointment. I understand that Motivate has reserved the right to change their privacy practices and a copy of any Revised Notice will be provided to me or made available.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Evaluation reports and/or clinical information is automatically sent to your referring provider. Any other records for any other reason will not be released without a completed and signed records release form from you.

ASSIGNMENT OF INSURANCE BENEFITS/REFERRALS/PAYMENTS GUARANTEE/COLLECTION FEE/NSF FEE

I hereby authorize payment to be made directly to Motivate for insurance benefits payable to me. I understand that I am financially responsible to Motivate for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I understand I am financially responsible for payment in full if no required referral is received by this office. I understand that I am financially responsible for any collection fee and any reasonable attorney's fees and other costs incurred for collection including but not limited to 1 ½% interest per month on any outstanding amounts unpaid 90 days after insurance resolution. I understand that I am financially responsible for a returned check for any reason and a $25.00 NSF fee. I understand that I can be terminated from the practice for monetary reasons ***or*** non-compliance with medical advice.

PAYMENT POLICY

I understand a courtesy insurance benefits quote may be provided to me. I understand this courtesy quote is not a guarantee of benefits and for accurate details regarding my benefits I should contact my plan administrator, health benefits coordinator or other designated agent. I also understand I may be required to sign an agreed upon payment policy based on findings from courtesy benefits quote. Self Pay Program payments are due at the time of service. The Adult/Guardian who brings a Minor will be responsible for any designated payments.

IF MY INSURANCE CHANGES OR I HAVE NO CURRENT INSURANCE CARD(S) AT TIME OF SERVICE

If I do not have my current insurance card(s) for any date of services, I will be billed as a Self Pay. Motivate might not be able to back date from the time of service to when I do present my current insurance card(s) to Motivate. I may be asked to seek reimbursement from my insurance carrier(s).

MEDICARE

Patient's Certification, Authorization to Release Information and Payment Request. I certify that the information given by me in applying for payment under TitleXVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to Motivate.

PATIENT ACKNOWLEDGEMENT

I have read the Agreement and Authorization form and I understand its contents and that I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of the form and that any statement may not amend to contents of the form. I understand that the records/information released will not be further disclosed for any purpose other than as stated in this Authorization.

X ______________________________	X ______________________________	X ____________
Patient or Authorized Representative PRINTED NAME	Patient or Authorized Representative SIGNATURE	Date

Authorization to Release Protected Health Information to Family Members or Other Individuals

In the event of a critical episode or if you are unable to provide authorization due to the severity of your medical conditions, HIPAA allows Motivate to disclose, without authorization, your protected health information as necessary to provide appropriate medical care.

Please check the appropriate box below (or leave blank):

_____ **I authorize** Motivate to release information concerning my medical care to the following individuals*:

Name (please print)	Relationship	Telephone #

_____ **I DO NOT** authorize Motivate to release any information to any individual

*This authorization does not expire unless you notify Motivate, in writing, of revocation

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Authorization for Motivate to Leave Voice Messages

You are automatically enrolled in automated appointment reminder calls. You should receive a reminder call 72 hours prior to your appointment.

1. You are automatically enrolled in automated appointment reminder calls. You should receive a reminder call 72 hours prior to your appointment.

If you do not wish to receive automated reminder calls, or would prefer to receive text reminders, please inform our Customer Care Team.

2. On occasion, we may need to contact you. A detailed voicemail may be necessary.

Please check the appropriate box below:

____ **I AUTHORIZE** detailed voice messages

____ **I DO NOT** authorize detailed voice messages

Please fill out this form as completely as possible.

This will help your therapist develop a safe and appropriate treatment for you.
We appreciate your input!

Today's Date ___________________________________

We recognize that the identities you carry might differ from legal and insurance identification. To ensure we are identifying you correctly while also avoiding billing/claim errors, please complete this section to your level of comfort.

Legal Name for Billing/Insurance _____________________________ Chosen First Name ____________________

Sex Assigned at Birth __________________

Current gender identity: ☐ He/him ☐ She/her ☐ They/them ☐ Another pronoun____________________

Emergency Contact Name: ____________________________ Emergency Contact Phone #_____________________

Your Preferred Phone # __________________________ Email Address ____

Occupation: ____ _____ FT ____PT ____Retired ____Unemployed

Hours/Week______ On disability or leave? ______ Activity Restrictions? __________________________________

How did you hear about us? ____

What is your primary problem? ____

When and how did your problem begin? ____

Is this… Work related____ Injury Date________ Auto Related____ Injury Date________ N/A____
Other/Describe____

Surgery for this condition? ☐ Yes ☐ No Date of surgery ___/___/_____

Type of surgery ____

Have you had any previous treatment for this condition? ☐ Physical Therapy ☐ Occupational Therapy
☐ Injection ☐ Chiropractic ☐ Pain Clinic ☐ Acupuncture ☐ Massage Therapy ☐ Other: _______________

Are your symptoms? ☐ Constant ☐ Comes and goes daily ☐ Occasional (< daily) ☐ Sporadic (< weekly)

Symptom Description: ☐ Aching ☐ Stabbing ☐ Burning ☐ Dull ☐ Steady ☐ Throbbing
☐ Numbness/Tingling ☐ Other: ________________________________

Can you get comfortable at night? ☐ Yes ☐ No Does time of day affect your symptoms ☐ Yes ☐ No

No pain 0 1 2 3 4 5 6 7 8 9 10 Intolerable pain

Circle your pain estimate (if applicable)

Not interfering with quality of life 0 1 2 3 4 5 6 7 8 9 10 Completely interfering with quality of life

Circle your perceived severity of symptoms

What are your goals with therapy?

____

____

Activities/events that cause or aggravate your symptoms. Check all that apply

☐ Sitting greater than______minutes
☐ Walking greater than ______minutes
☐ Standing greater than ______minutes
☐ Changing positions (e.g., sit to stand)
☐ Light activity (light housework)
☐ Vigorous activity/exercise (run/weight lift/jump)
☐ Sexual activity
☐ With cough/sneeze/straining
☐ With laughing/yelling
☐ With lifting/bending
☐ With cold weather
☐ With triggers (e.g., key in door)
☐ With nervousness/anxiety
☐ No activity affects the problem
☐ Other, please list: ____

How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify___________________________________

____

Diet/Fluid intake, specify____

____

Physical activity, specify____

____

General Health (circle one): Excellent Good Average Fair Poor

Mental Health Current level of stress: High Med Low Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Check all that apply

☐ Cancer
☐ Heart problems
☐ High blood pressure
☐ Ankle swelling
☐ Epilepsy/Seizures
☐ Multiple Sclerosis
☐ Fibromyalgia
☐ Diabetes
☐ Hypo/Hyperthyroid
☐ Stroke
☐ Substance abuse
☐ Raynaud's Syndrome
☐ Acid reflux/Belching
☐ Anorexia/Bulimia
☐ History of smoking

☐ Anemia
☐ Osteoporosis
☐ Deep vein thrombosis/Embolism
☐ Headaches
☐ Head injury
☐ Emphysema/Chronic bronchitis
☐ Asthma
☐ Allergies (list below)
☐ Latex sensitivity
☐ Arthritic conditions
☐ Joint replacement
☐ Bone fracture
☐ Sports injuries
☐ TMJ/Neck pain
☐ Vision/Eye problems

☐ Childhood bladder problem
☐ Irritable Bowel Syndrome
☐ IBD (Crohn's/UC)
☐ Pelvic pain
☐ Hepatitis
☐ Low back pain
☐ Sacroiliac/Tailbone pain
☐ Sexually Transmitted Infection
☐ Physical/Sexual Abuse
☐ Kidney disease
☐ Current infection (describe below)
☐ Frequent UTIs
☐ History of MDROs (MRSA, VRE, etc.)
☐ Other communicable diseases (describe below)

Other/Describe____

____

Surgical/Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs

Other/Describe____

____

Medications - pills, injection, patch	**Start date**	**Reason for taking**

Over the counter - Vitamins etc.	**Start date**	**Reason for taking**

X ______________________________ **X** ____________________

Patient or Authorized Representative Signature Date

LATE CANCEL / NO SHOW POLICY – *revised 8/26/21*

Our goal is for you is to complete an agreed upon a personalized Plan of Care in a reasonable amount of time. Your dedication to keeping your scheduled appointments is key to your success.

We reserve one hour time slots to provide you with highest quality of care.
To provide this type of care, it is imperative that you attend your scheduled commitment.
Late cancellations and no shows limit opportunities for patients waiting for access to excellent care.

Motivate Health, Inc. requires 48-hour notice for all appointment cancellations

- **IF Motivate Health, Inc. does not receive 48-hour notice,** you will be charged a $100 fee to cover the cost of the visit.*

*****Exceptions from this charge are contagious illness or pandemic restrictions*

Motivate Health, Inc. reserves the right to cancel future scheduled appointments due to 2 consecutive late cancels or no shows

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- **Cancellations are accepted only by calling during Motivate office business hours Monday – Friday 8am – 4:00pm***

Monday and Tuesday appointments - voice message cancellations recorded on Motivate voice mail Saturday or Sunday are acceptable and must be recorded 48 hours prior to appointment

- **Email, text, and social media messages to cancel are not acceptable**

No exception

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Courtesy automated text message appointment reminders are available.
See our Customer Care Team for details.

____

Patient Printed Name

____________________________________ ________________________

Patient signature of acknowledgement **Date**