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

I hereby authorize Motivate to release information required in the processing of application for financial coverage for services rendered. This authorization provides that my physician or my physician's staff may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. This authorization also includes any medical records containing information related to HIV (Aids) testing and/or psychiatric care rendered to me if such records are released to an insurance company writing Life, Accident or Health Insurance or a Non Profit Health Care Service Plan Corporation to evaluate my claims or its liability under such policies or contracts or coordination of benefits pursuant to such policy or contract provisions. The information obtained will be treated as privileged and confidential and will not be released to any person without my expressed or written consent. Correspondence and test results will only be released to physicians involved in my care.

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

Motivate Health requires payment policies from all patients whether covered by insurance or Self Pay Program option. I understand I will be required to sign agreed upon Payment Policy. The Adult/Guardian who brings a minor will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court ruling or divorce decrees.

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 Program. Motivate may 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______________________________	________________
Patient or Authorized Representative **Printed Name**	Patient or Authorized Representative **Signature**	**DATE**

Please fill out this form as completely as possible.

This will assist your therapist in developing 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 and Insurance ____________________________ Chosen Name___________________________

Sex Assigned at Birth___________________

Current gender identity: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Another pronoun_____________________

Emergency Contact Name: __________________________ Emergency Contact Phone #__________________________

Your Preferred Phone # ________________________ Email Address____

Employment Status ___FT ___PT ___Retired ___Unemployed Employed at ______________________________

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 (less than daily) ☐ Sporadic (less than weekly)

Symptom Description: ☐ Aching ☐ Stabbing ☐ Burning ☐ Dull ☐ Steady ☐Throbbing ☐ Numbness/Tingling ☐ None of these

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

Motivate™
PERSONAL PHYSICAL REHABILITATION
Change Starts Here

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

Circle your pain estimate (if applicable)

Not interfering 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 (ie: - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list ______________________________

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers i.e. /key in door
___ With nervousness/anxiety
___ No activity affects the problem

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: Excellent Good Average Fair Poor Occupation ______________

Hours/week_______ On disability or leave? ______ Activity Restrictions? ______________

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
___Anemia
___Low back pain
___Sacroiliac/Tailbone pain
___Alcoholism/Drug problem
___Childhood bladder problem
___Depression
___Anorexia/bulimia
___Smoking history
___Vision/eye problems
___Hearing loss/problems
___Stroke
___Epilepsy/seizures
___Multiple sclerosis
___Head Injury
___Osteoporosis
___Chronic Fatigue Syndrome
___Fibromyalgia
___Arthritic conditions
___Stress fracture
___Acid Reflux/Belching
___Joint Replacement
___Bone Fracture
___Sports Injuries
___TMJ/ neck pain
___Emphysema/Chronic bronchitis
___Asthma
___Allergies-List below
___Latex sensitivity
___Hypothyroid/Hyperthyroid
___Headaches
___Diabetes
___Kidney disease
___Irritable Bowel Syndrome
___Hepatitis
___Sexually transmitted disease
___Physical or Sexual abuse
___Raynaud's (cold hands and feet)
___Pelvic pain

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____

____

Ob/Gyn History

Y/N Childbirth vaginal deliveries # ______
Y/N Episiotomy #______
Y/N C-Section #______
Y/N Difficult childbirth ______
Y/N Prolapse or organ falling out
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - When? ________________
Y/N Painful vaginal penetration
Y/N Pelvic/Genital pain

Other/Describe____

____

Urology History

Y/N Prostate disorders
Y/N Shy bladder
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Pelvic/Genital pain, describe location____

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 for you is to complete agreed upon Plan of Care designed for you 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. In order 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 $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 schedule appointments due to 2 consecutive late cancels or no shows

****

- **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 report cancellations are not acceptable**

no exceptions

****

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

____

Patient Printed Name

____ ________________________________

Patient signature of acknowledgement **Date**