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Advanced Institute of
Physical Therapy

PERSONAL MEDICAL DATA FORM

PERSONAL INFORMATION

Name: _____ DOB: _____

Address: _____

_____ _____ _____

City State Zip code

Cell Phone: _____ Home Phone: _____

E-mail address: _____

Emergency contact/relationship: _____ Phone: _____

Occupation: _____

Please check any of the following symptoms you have experience in the past six months.

☐ Upper back pain	☐ Shoulder pain	☐ Tingling/Numbness	☐ Fatigue/Depression
☐ Lower back pain	☐ High Blood Pressure	☐ Dizziness/Vertigo	☐ Muscular Aches
☐ Headaches	☐ Stiff Neck	☐ Constipation	☐ Carpal Tunnel
☐ Stomach	☐ Allergies	☐ Osteoporosis	☐ Arthritis
☐ Fibromyalgia	☐ Bruising disorders	☐ Vision change	☐ Asthma
☐ Heart problems	☐ Sinus Problems	☐ PMS Problems	☐ Bladder Problems

How long have you suffered these symptoms? ___ weeks ___ months ___ years

Have you ever had an accident?

_____ Auto ___/_____ (MM/YYYY) _____ Work ___/_____ (MM/YYYY)

_____ Other ___/_____ (MM/YYYY) _____ None

HEALTH INSURANCE

Information below is to check coverage ONLY

Do you have medical insurance? Please select the coverage you have.

☐ Medicare	☐ Tricare	☐ WPS VA	☐ UHC	☐ UHA
☐ HMSA/BCBS	☐ HMA	☐ HMAA	☐ Ohana	☐ Ohana SMG
☐ Devoted	☐ MDX	☐ Humana	☐ UFCW-HI	☐ Aloha Care
☐ HMO	☐ PPO	☐ HPH	☐ Quest	☐ Other

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

1 (808) 600-9148
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For **Work** Related Injuries:
Name of Employer: _____ Phone: _____
WCOMP Insurance: _____ DOI: _____ Claim No.: _____
Adjuster Name: _____ Phone: _____ Fax: _____

For **MVA** Related Injuries:
Name of Employer: _____ Phone: _____
MVA Insurance: _____ DOI: _____ Claim No.: _____
Adjuster Name: _____Phone: _____ Fax: _____

Do you have an attorney for your accident or injury? ___ Yes ___ No
If yes, please fill out the following:
Attorney's Name: _____ Phone: _____ Fax: _____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement, and initial your agreement.

Initials

_____ I instruct the provider to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health.

_____ I acknowledge and may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realized that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I received.

_____ I acknowledge that I have informed the front desk of any and all insurance(s) I have. I have not withheld any additional insurance information. I understand that I will be fully financially responsible for giving false information in regards to my insurance.

_____ I acknowledge that should any of my insurance information change (i.e., plan type, subscriber, etc.) I will immediately inform the front desk.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

_____ **I acknowledge that a 24-hour cancellation notice is required. Without proper notification a missed appointment may result in a $30 cancellation fee.**

If the patient is a minor child, print child's full name: _____

Signature: _____ Date: _____

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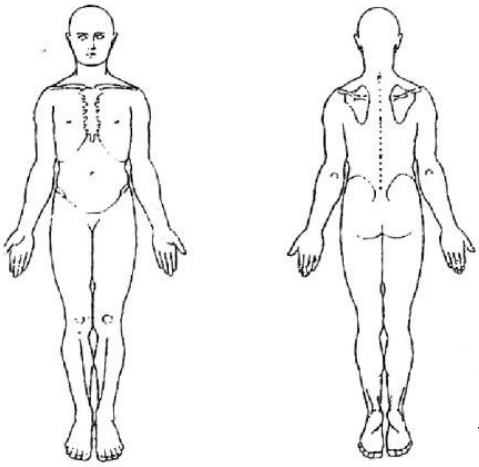
Name: _____ DOB: _____

Referred by: _____

Chief complaint: _____

Put an "X" for current pain



Rate your pain on the scale below.

When did the problem begin? _____

Has the problem affected your daily life? (i.e., job and exercising) _____

_____

_____

Have you had previous or similar occurrences of these symptoms? ___ Yes ___ No

If yes, please describe _____

_____

Date of special tests (MRI, X-ray) and findings: _____

_____

Past medical history with dates (accidents, injuries, falls, surgeries): _____

_____

Current medications: _____

What are your current physical activities and how have they changed? _____

_____

What are your goals and expectations of physical therapy? _____

_____

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CONDITION AND CONSENT FOR OUTPATIENT TREATMENT

In order for physical therapy to be most effective, I understand that:

COOPERATION WITH TREATMENT

I must attend my appointments as scheduled unless there are unusual circumstances that could prevent me from attending therapy. I understand that I may be discharged from physical therapy if I fail to keep three (3) appointments without calling at least 24 hours in advance to cancel. I agree to cooperate with the home program assigned to me. If I have difficulty fulfilling my program, I will discuss this with my therapist.

NO GUARANTEE

The staff of the physical therapy department does not promise me a cure for my condition. They will share with me the available statistics and studies regarding the results of physical therapy treatment for my condition. They will discuss all treatment options with me.

INFORMED CONSENT TO TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The staff of the physical therapy department provides a wide scope of services and will dispense information at the initial visit on the treatment/assessment options available for my condition.

POTENTIAL RISKS

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is generally temporary and will probably subside in 24 to 48 hours.

POTENTIAL BENEFITS

I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may also experience decreased pain. Ultimately, I will have greater knowledge about managing my condition and the resources available to me.

ALTERNATIVES

All physical therapy treatment options available for my condition will be explained to me. I may inquire on the cost of these services and discuss them with my therapist. If I do not wish to participate in the program, I may discuss my medical, surgical, or pharmacological alternatives with my physician.

INSURANCE INFORMATION

As a courtesy to you, we will bill your insurance company. But it is your responsibility to know your policy benefits and limitations. Any portion of your treatment that is not covered by your insurance becomes your responsibility. For workers compensation and MVAs claims, please be advised that you are financially responsible for all charges in the event that your claim is denied.

Based on the information I have received from the therapist; I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

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Credit Card On File Policy

To Our Patients:

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely. If you have ever stayed in a hotel or rented a car, you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due. As of May 1, 2025, Movement Plus Physical Therapy has adopted a Credit Card on File Policy.

Once we receive your Explanation of Benefits (EOB) (what the insurance company will pay towards your visit), we will wait 30 days to allow you time to pay the balance on your account. If your balance is not paid, your credit card will be charged for the outstanding balance that is your responsibility. Co-pays must be paid at the time of visit. If you have any questions about this payment method, please do not hesitate to call our **Billing Office** at **808-600-9148.**

How does credit card on file benefit me?
Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts sent via email

Please note that all of your rights with respect to the use of your credit card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment.

Your credit card on file can be used for the following reasons:
-Visit payments not collected from you at the beginning of the visit
-No show or late cancellation charges
-Insurance discrepancies
-Outstanding balance greater than 31 days past due

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Authorization Form

****Please do not send this form over email. Bring this form with you at your first appointment****

Credit Card Type (circle) Visa MasterCard Discover Amex

Credit Card Number | Exp Date | CVV/CVC | Name as it appears on card

Billing Address | City | State | Zip

Phone Number | Email

Patient Name | DOB | Patient Name | DOB

Patient Name | DOB | Patient Name | DOB

I authorize Movement Plus Physical Therapy (MPPT) to charge the credit card above per the terms of this policy. This authorization shall remain in effect until MPPT has received written notification from me of its termination.

Signature | Date

The information will be immediately uploaded into our payment system, a highly secured and certified. All card numbers are encrypted and decryption keys are stored on separate machines from the card data.

The credit card number and CVV/CVC on this paper authorization will be redacted prior to uploading to the patient's medical records. Once a copy of the authorization has been uploaded, this paper authorization will be destroyed.

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