Financial Responsibility
Midline Movement PLLC

Thank you so much for choosing Midline Movement Physical Therapy PLLC as your choice for physical therapy. It is our duty and commitment to provide superior care in order to obtain results that go above and beyond standard expectations. As we commit to you, it is expected from you as a patient that our relationship is mutual.

Billing and Insurance

Midline Movement is a private practice entity that does not participate with any insurance provider in any case. All treatments are expected to be paid in full and it is your responsibility to understand this. Although we do not participate with any insurance provider, a bill will be given if requested with the provided treatment which can be submitted to any primary insurance provider for possible reimbursement. Having no affiliation with any insurance allows the therapist and patient to be in control of what is necessary for optimal outcomes. This removes any influence from reimbursing insurance companies to pursued therapist treatment based on reimbursement cost.

We do accept payment using a HAS /HRA /FSA, but you must have a valid and active card that can be used for payment at the time of service. If you do not, then a receipt of your treatment will be issued and can be submitted for reimbursement directly to you.

*Payment plans and other forms of payment can be made but must be arranged prior to your initial treatment with Midline Movement.
*Those that are financially responsible for a payment plan must understand that if payment is not made within 60 days of past due their bill will be submitted for collections and continued services will be put on hold per therapist discretion at Midline Movement.
*Those choosing not to utilize any form of a payment plan are expected to pay at the time that service is rendered. Those who have delinquent accounts have 90 days form the last service before the outstanding balance will be sent to collections and treatment will be withheld per therapist discretion at Midline Movement PLLC.

Missed Appointments

Patients will not be billed for missed appointments if 24 hours of notice is given prior. It is expected from you as a patient and our therapists that there is mutual respect for our business and other patients. If you do not provide at least 24 hours' notice you will be assessed a $30 fee. If multiple appointments are noted with failure to show it is up to Midline Movement to determine scheduling further appointments.

Your signature on this form states that you understand and agree that it is your financial responsibility for all balances on your account for any services undergone at Midline Movement PLLC. I understand that I have given up my right for insurance reimbursement for all services during treatment at Midline Movement PLLC. If I choose to seek reimbursement I must personally do so with my insurer while willingly and knowingly that Midline Movement has no responsible or obligation.

Signature X ______________________________ ____________________
Patient/Responsible party (Over 18) Date

Midline Movement
Physical Therapy
Joseph Kik DPT, PTA, CPT
Phone: 616-765-2299 Email: kikj@mindlinemovement.com

Patient Consent Form

Our Notice of Privacy Practices provides information about how our clinic may use and disclose protected health information about you. The Notice contains a Patient Rights section that describes your rights under the law. You will have the right to review the Privacy Practices Notice before signing this Consent. The terms of our notice may change at any time. If there are any changes made to our Notice, you may obtain a revised copy by contacting our HIPPA officer at 616-765-2299.

Midline Movement provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations when necessary.
- Midline Movement has a Notice of Privacy Practices posted for patients review
- Midline Movement reserves the right to change the Notice of Privacy Practices
- All patients have the right to restrict the use of their information but Midline Movement does not have to agree with those restrictions.
- The patient may revoke the Consent in writing at any time and all future disclosures will then cease. However, such a revocation shall not affect any disclosure we have already made in the reliance on you prior to Consent.
- Midline Movement may condition delivery of treatment upon the execution of this Consent.

This Consent was read by: ____
(Printed Name-Patient or Representation)

____ ____/____/____
(Signature) (Date)

Witness ____ ____/____/____
(Midline Movement Representative (Date)

Midline Movement Physical Therapy Patient Personal Information Form

Name: ______________________________ ___ ______________________________

(First) (M.I.) (Last)

Address: ______________________________ City: ______________________________

State:________ Zip______________________ DOB: ______________________________

***Use preferred contact phone number**

Age: __________

Home Phone: (_____)______________________ Cell: (_____)______________________

Email: ______________________________ Occupation: ______________________________

Employer: ______________________________

Referring Doctor: ____

Emergency Contact:

Name: ____

Relationship: ____

Contact number: (____) ____

Other:

How did you hear about our clinic? ____

____

Please Provide any feedback you think is necessary in the lines below:

____

____

____

HIPAA Information Release Authorization
Midline Movement Physical Therapy
PLLC

I hereby authorize Midline Movement Physical Therapy PLLC to release any health information deemed necessary including appointment reminders, diagnosis, and records of any treatment, examination or evaluation performed, and all financial records to the person undersigned below:

______________________________________ ______________________

(Name of person being authorized) (Relationship to Patient)
*No persons can be used if you do not want to authorize anyone

____

(Patient's Name: Print)

X ____________________________________ ______________________
(Patient Signature or Parent/Guardian if Under 18) (Date)

Midline Movement Physical Therapy PLLC
Intake Form

Name: ______________________________ Age_____ DOB ______________

Referring Physician: ______________________________ Occupation: ______________

Date: ______________________________ Date of Injury: ______________

Diagnosis: ______________________________

Please briefly describe why you are seeking physical therapy: ______________________________

____

____

Was there a traumatic event that occurred? _______ If so, please explain: ______________________________

Please explain the symptoms you are feeling:

☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Electrical ☐ Cramping ☐ Numbness/Tingling ☐ Achy

Pain is: ☐ Localized ☐ Radiating

If none of these describe the pain, explain: ______________________________

Pain Scale (Please Circle)

Pain at best: (0=Best, 10=Worse) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Pain at the worse: (0=Best, 10=Worse) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What increases your pain? ______________________________

What decreases your pain? ______________________________

Are you having difficulty sleeping? (Y/N) _____If yes, what is the most painful position? __________

-Pain with sneezing? (Y/N) _______

-Excessive Weight Loss past 2 weeks (Y/N) _____

-Back pain at night (Y/N) _____

-Dizziness or blackouts (Y/ N) _____

-Bowel or bladder Issues? (Y/N) _____

-Fever (Y/N) ____

-Abnormal Numbness or tingling (Y/N)____

What does your daily routine consist of? ______________________________

____

Are you currently physically active? (Y/N) ________ If so, list activities/exercise ______________________________

____

Have you had any other prior treatment before your arrival today? (Check all that apply)

☐ Primary Care ☐ Orthopedist ☐ Pediatrist ☐ Chiropractic ☐ Pain Clinic ☐ Natural Doctor

☐ Physical Therapy ☐ Other Specialist

Has anything helped in the past? ______________________________

What is your goal for therapy? ______________________________

____

Past Medical History

Currently/Past Conditions: ______________________________

____

____

Medications (Please List or Attach Separate Paper):

____

____

Allergies: ______________________________

____

MIDLINE MVMT
PHYSICAL THERAPY

Midline Movement Physical Therapy PLLC

1.) Place a Mark on the line for current pain, worse, and best (three makes total indicating by C/W/B)

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

2.) Indicate you pain on the body diagram using the following:

O O O O = Pins/Needles

^ ^ ^ ^ = Burning

X X X X =Aching

//// = Stabbing/Sharp

Joseph Kik, DPT, PTA, CPT
Midline Movement Physical Therapy PLLC
1515 Michigan St NE Grand Rapids, MI 49503-2031 Ste#106
Phone: 616-765-2299 Fax: 616-336-5101

Patient Referral Form

Patient Name: ______________________________

DOB: ______________ Phone Number: ______________

Diagnosis: 1.)______________ 2.)______________

3.)______________ 4.)______________

5.)______________ 6.)______________

Precautions: ______________________________

Frequency and Duration of Treatment:

☐ **Evaluate and Treat**
☐ **At Therapist Discretion**
Or
_______ times per week for ______week(s) or month(s)

Treatment Plan:

☐ **At therapist Discretion**
Or

☐ Manual Therapy ☐ Therapeutic Exercise ☐ Therapeutic Activity
☐ Neuromuscular Re-Ed ☐ Gait Training ☐ Functional Training
☐ Modalities: ______________
☐ Other: ______________

Special Instructions:

____

____

*I certify/recertify the need for these services furnished under this plan of treatment while under my care

Printed Name ______________________ **Fax (____)**______________

Physicians Signature ______________________ **Date** ______________

Comments:______________________________

____