Mobility with Lilly
mobilitywithlilly.com

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the full cost of the treatment session prior to or at time of appointment. We accept cash, credit card, debit card, checks)previous approval required). Mobility with Lilly does not accept insurance at this time. If your insurance supports Out of Network providers, we will provide you a receipt for reimbursement. It is the patient's responsibility to understand their insurance benefits.

The signature below confirms financial responsibility for payments by the patient or the patient representative.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Print Name of Patient or Patient Representative Relationship to Patient

Patient Information For Out of Network Insurance Documentation

Name _____ DOB_____ Age_____

Address _____

Cell # _____ Home #_____

Last 4 digits of SSN ***-**-_____ Email _____

ICD 10 code (PT diagnosis) _____

Insurance Carrier _____

Insured: Self Spouse Other _____

Ins. ID # _____ Policy #_____

Medical Intake Form

Patient Name: _____ Condition Begin Date ____ / ____ / _____

Work Status: Full Time / Part Time / Off Duty On the job injury? Yes / No

Rate Your Pain (0 = No Pain, 10 = Worst Pain You Can Imagine)
Symptoms at Worst: ____ Symptoms at Best: ____ Symptoms Today: ____

How much does pain limit activity? _____ %

Current Medications (include ALL known prescriptions, over the counters, herbals and vitamin/mineral/dietary/nutritional supplements) ____ List Attached ___Not currently taking any prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements

Medication / Dose / Frequency / Method	Medication / Dose / Frequency / Method
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____

Past Surgical History Type of Surgery	Date Type of Surgery Date
_____ ____/____/ ____	_____ ____/____/ ____
_____ ____/____/ ____	_____ ____/____/ ____

Have you had any of the following diagnostic, medical, or rehabilitative services for this injury/episode?

☐ Chiropractor	☐ Physical Therapy	☐ Occupational Therapy	☐ Massage Therapy	☐ CT Scan
☐ Orthopedist	☐ Myelogram	☐ Neurologist	☐ EMG/NCV	☐ MRI
☐ Practitioner	☐ Podiatrist	☐ ER	☐ x-Rays	

Past Medical History:
Please check any condition you currently have OR have ever had in the past.

☐ Asthma	☐ Cancer	☐ Rheumatoid Arthritis	☐ High Blood Pressure
☐ Diabetes	☐ Clots	☐ Thyroid Trouble/Goiter	☐ Neurologic Disorder

Past Medical History (cont'd):

☐ Anemia	☐ Anxiety	☐ Pins or Metal Implants	☐ Osteoporosis
☐ Gout	☐ Seizures	☐ Sleep Problems	☐ Concussion
☐ Stroke	☐ Pacemaker	☐ Fibromyalgia	☐ Varicose Veins
☐ Hernia	☐ Depression	☐ High Blood Pressure	☐ Heart Problems
☐ Other _____		☐ Pins/Metal Implants	☐ Migraines/Headache

Allergies _____

Please check if exposure to any of the following will affect your treatment negatively:

☐ lotion ☐ essential oils ☐ cat ☐ dog

Have you experienced any of these symptoms recently (please check all that apply)

☐ Chest Pain	☐ Pain with Meals	☐ Nausea/Vomiting
☐ Dizziness	☐ Vision Changes	☐ Memory Problems
☐ Unusual Weakness	☐ Poor Balance/Falls	☐ Fever/Chills/Sweats
☐ Difficulty Speaking	☐ Numbness/Tingling	☐ Changes in Appetite
☐ Difficulty Swallowing	☐ Change in Bowel Habits/Control	☐ Confusion/Brain Fog
☐ Unusual Pain w/ Menstruation	☐ Unexplained Weight Loss/Gain	☐ Increased Pain at Night/Rest
☐ Other: _____	☐ Other: _____	☐ Shortness of Breath

Additional Information

Smoker: Yes / No If yes, _____packs per day

Alcohol Use: Yes / No If yes, drinks per day

Possibly Pregnant: Yes / No

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Patient Representative Signature	Print Name	Date

New Patient Acknowledgments

Patient Name: _____ Date: _____

☐ Consent to Treatment	I consent to and authorize Mobility with Lilly to administer rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my physical therapist about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.
☐ Notice of Privacy Practices	I hereby acknowledge that I have been made aware of Mobility with Lilly's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the office and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.
☐ Authorization to Release / Obtain Information	I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Mobility with Lilly to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.
☐ Out of Network Provider	We are an Out of Network Provider. Payment is due directly to Mobility with Lilly at the time of treatment. We can provide a paid receipt with insurance codes for you to submit to your insurance provider for reimbursement. Reimbursement amount is determined by your insurance benefits. It is your responsibility to fully understand your insurance benefits.

☐ Financial Responsibility	Payment is due at the time of treatment. I agree to pay Mobility with Lilly all amounts that are due for services rendered. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.
☐ Appointments / Cancellations	We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for a speedy recovery. We expect you to keep all of your appointments with Mobility with Lilly and require 24 hours notice if you are unable to keep an appointment. We recommend rescheduling the appointment at time of cancellation. If unable to reschedule, you will be charged for the visit.

Patient/Patient Representative Signature	Print Name	Date