



Patient Registration Form – Self Pay

Patient Name:		Preferred:	
Address, City, State, Zip:			
DOB:		Social Security #:	
Email Address:			
Home Phone:		Appointment Reminder Method	
Cell Phone:		<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone
Work Phone:		<input type="checkbox"/> Work Phone	<input type="checkbox"/> Email
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Partner's Name:	
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other, Please List Parent/Legal Guardian Name:			
Address and Phone Number, If Different from Above:			
Social Security #:		DOB:	Relation:
2nd Contact Info and Phone:		Relation:	
General Physician:		Referred by:	
Have you had Physical Therapy treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:			
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:			
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, Home Healthcare Provider:			

Consent to Treat/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at Health In Motion and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I certify that the information I have provided is accurate and complete. In signing this form, I will promptly pay any required amounts due at the time services are rendered.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

Signature of Patient/Guardian Date

Print Name Relationship to the Patient

Release of Information

I hereby authorized Health In Motion to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
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Name (print)	Relationship	Phone number
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Name (print)	Relationship	Phone number
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Patient/Guardian Signature:	Date:
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Patient name:	DOB:
Authorization for Communication	
<p>By providing my above contact information and signing below, I consent and authorize Health In Motion and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.</p> <p>I also understand that I may revoke my consent to contact at any time by directly contacting Health In Motion or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Health In Motion immediately of any change in telephone number or email address.</p> <p>Please check the box below to opt in to receive messaging.</p> <p><input type="checkbox"/> I consent to receiving text messages about care, appointment reminders, and important health reminders from Health In Motion at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy here.</p> <p>https://himwi.com/wp-content/uploads/sites/43/2025/12/HIM-Website-Privacy-Policy-Terms-11-2025.pdf</p> <p><input type="checkbox"/> I do not consent to receiving text messages.</p>	
Patient/Guardian Signature:	Date:

Patient name:	DOB:
Patient Elect to Self-Pay for Services	
<p>If you do not want Health In Motion to file claims to your personal health insurance, please read and sign below or please indicate if you do not have personal health insurance and sign below. <i>I acknowledge that I understand and agree that:</i></p> <ul style="list-style-type: none"> ✓ I am covered by the health insurance plan. ✓ The Health Plan under which I am covered includes benefits for some or all the services provided by Health In Motion. ✓ Despite the above, I do not wish Health In Motion to submit a claim to my Health Plan for services provided to me. ✓ Until such time as I may otherwise advise Health In Motion in writing, I elect to pay for all services I receive at their self-pay rates. ✓ By election to self-pay for services, I understand that Health In Motion will not be submitting claims to my Health Plan and that any payments I make to Health In Motion will NOT be credited toward satisfying any deductibles, plan maximums, etc. ✓ I have read the Election to Self-Pay for Services and have had the opportunity to ask any questions I may have, and my questions have been answered to my satisfaction. <p><input type="checkbox"/> I do not have health insurance coverage.</p>	
Patient/Guardian Signature:	Date:

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of Health In Motion to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of \$50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

Signature of patient/authorized representative Date

Printed name Relationship to patient

Audio Recording Technology Patient Consent Form for Use of AI Medical Scribe

At Health In Motion, we use AI medical scribe technology to help our clinicians quickly and efficiently complete the required documentation associated with your visit in accordance with healthcare regulations. The technology we use is Health Insurance Portability and Accountability Act (HIPAA)- compliant and ensures your privacy and confidentiality. document your care more efficiently and accurately.

How It Works:

- During your visit, your clinician may use AI-supported audio recording tools to record conversations and create accurate clinical notes and medical records.
- **No recordings are saved.** Your voice recordings are always permanently deleted once the clinician has completed their documentation. The recording can never be retrieved or accessed again by our organization or the technology company. This process will never take longer than 60 days, and these recordings will be used for no other purpose. The recordings will never be used for data sharing and data sales.

Your Privacy and Rights:

- Our AI audio recording technology is fully compliant with HIPAA, meaning your privacy and personal health information are fully protected, including your voice blueprint.
- The use of this technology does not affect the quality of care you receive, nor does it allow your information to be shared or stored outside of your medical record.
- You have the right to ask questions or decline the use of this technology at any time during your care.

By signing below, both Patient and Clinician acknowledge that they have been informed about the use of AI medical scribe technology and consent to its use as part of this patient visit. You understand that no recordings are permanently stored and that the technology is used solely for documentation purposes.

I do not consent to use of AI Medical Scribe

Signature of patient/authorized representative Date

Printed name Relationship to patient

Patient name:		DOB:	
PATIENT HEALTH QUESTIONNAIRE			
Occupation:	Height:	Weight:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Leisure Activities/Hobbies:			
Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed			
Where do you live? <input type="checkbox"/> Private Home <input type="checkbox"/> Apartment/Rented Room <input type="checkbox"/> Assisted Living/Group Home <input type="checkbox"/> Hospice <input type="checkbox"/> Other:			
With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse Only <input type="checkbox"/> Spouse and Others <input type="checkbox"/> Child <input type="checkbox"/> Other:			
Does your home have? <input type="checkbox"/> Stairs, No Railing <input type="checkbox"/> Stairs, Railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven Terrain Please Explain:			
How many times have you fallen in the past 12 months?		Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No			
General Health Status: Please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Please list any known allergies (including medications, latex, etc.) below.			

Social History / Wellness	
Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never	

Surgery / Hospitalization, Please Include Date and Reason.

Have you been diagnosed with any of the following?			
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	
Hepatitis, If Yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteopenia/Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	List	

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff with a list to copy.			
Name	Dosage	Frequency	Please Indicate Route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Are you currently experiencing any of the following?			
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Wakes Me at Night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Fever, Chills, Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss/Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Pain or Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Condition
When did this problem(s) first begin/date of onset?
If chronic, when did you seek medical treatment?
Is your current condition related to recent surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify date of surgery:
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?
Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same All Day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Staying the Same
My symptoms bother me: <input type="checkbox"/> Constantly (100%) <input type="checkbox"/> Most of the Time (75%) <input type="checkbox"/> Occasionally (50%) <input type="checkbox"/> Once in a While (25%)
Do you have any numbness, tingling, or burning? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please check one: <input type="checkbox"/> Constantly <input type="checkbox"/> Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please tell us what it is:
What are your goals for therapy?

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature: _____ Date: _____