PATIENT INTAKE FORM

PLEASE FILL OUT COMPLETELY AND CLEARLY

Date: **Patient's Legal Name:**

Nickname: **[ ] Male [ ] Female** **DOB:** **SSN:**

Mailing Address: **City/State/Zip:**

Main Phone: **Cell:** **Email Address:**

Primary Insurance: Secondary Insurance:

Primary Insured Name: Relationship to patient:

Primary Insured DOB: Primary Insured SSN:

Primary Insured Mailing Address *(if different from the above)*:

W O R K C O M P & M V A

Date of Injury:________________________________ **Claim #:**____

Insurance Company:____ **Phone #:**________________________________

Address:____ **State:**_________ **Zip:**____________________

Adjuster/Case Manager:____

Is an attorney involved? [ ] Yes [ ] No - Attorney Name/Phone#:____

Employer: Occupation:

Address: Phone#:

Medicaid Patients: *Who is your Passport Provider:* *Date of last visit:*

Have you had any therapy in the ***past 12 months***? [ ] PT [ ] OT [ ] Speech [ ] Chiropractic [ ] Cardiac/Pulmonary **or** [ ] No
If yes, when was it?_________ How many?______ Was it at our clinic [ ] Yes [ ] No Was it for the *same injury*? [ ] Yes [ ] No

Referring Physician: Phone:

Emergency Contact: Phone: Relationship:

Please sign below to acknowledge that the above information is accurate, that you have received the **HIPAA Notice of Privacy Practices** handout, and to authorize our clinic to treat for physical therapy.

Signature of Patient: Date:

Information below is *required for treatment of a minor or a patient who does not have their own power of attorney.*

Name of Parent or Legal Guardian: Signature:

[ ] I would like to receive appointment reminders via email.

PATIENT HEALTH SUMMARY

Name:____ Age:________ M F DOB:___________________________
Occupation/Student (grade):______________________________________ Hand Dominance: R / L *(circle one)*
Reason you are being seen today:____
Have you had any diagnostic testing for your current condition? If so, what tests:____
Date of injury or when your symptoms began:_________________________________
How were you injured?____
Describe your current symptoms:____
What makes your symptoms worse?____
What makes you feel better?____
How long can you stand?_________________________ sit?_________________________ walk?________________________________
Have you experienced afall within the past 12 months? [ ] Yes [ ] No If so, were you injured? [ ] Yes [ ] No
Do you have a previous history of the condition for which you are being seen today? Yes_____ No_____
What leisure/physical activities do you enjoy?____
What activities/movements can you no longer do due to your injury?____
What are your goals for therapy?____
Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes_____ No_____
Medication/Injection and condition taken/given for: ____
____

Please check all that apply to you:

___ Cancer
___ Heart Condition
___ High BP/hypertension
___ Pacemaker
___ Asthma
___ Lung Disease
___ Emphysema
___ Hepatitis/kidney problems
___ Tuberculosis
___ Phlebitis/Circulatory Problems
___ Stroke
___ Anemia
___ Infectious Disease
___ Diabetes
___ Glaucoma
___ Thyroid Problems
___ Arthritis
___ Multiple Sclerosis
___ Neurological Disorder
___ Prostate Condition
___ Bowel/bladder
___ Emotional Problems
___ Migraines/headaches
___ Dizzy Spells
___ Seizure
___ Tobacco use

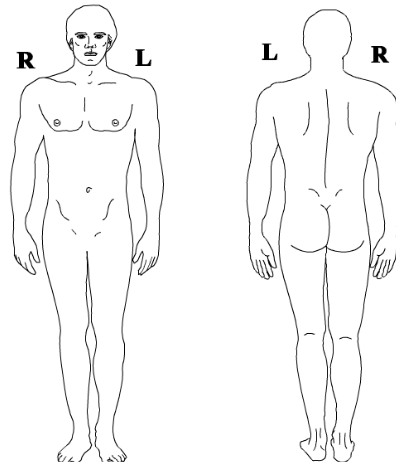
Are you currently pregnant? Yes_____ No_____
Is there anything else you feel we should be aware of? (fractures, other medical conditions)

____
List surgeries you've had: ____

Circle the number that best describes your status:

PAIN 0 1 2 3 4 5 6 7 8 9 10
Best ______________________________________Worst

Please shade in the areas where you are experiencing pain:



Please notify your therapist if there are any changes in your condition.
Thank you for coming to our clinic for your therapy needs.

Patient Signature Date
____

PATIENT FINANCIAL POLICIES

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. To accomplish this, we need your assistance and understanding of our payment policy.

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. **You will be responsible for paying for your visits until your deductible is met. Once your deductible is met, you will be responsible for your co-pay or co-insurance.**
2. **As a courtesy, we will verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.**
3. Not all services are covered in all contracts. Some insurance companies select certain services they will not cover. **These services, if applicable, are your responsibility**.
4. If you have more than one insurance, you will be responsible for disclosing all insurances to us, as well as alerting each insurance of any additional coverages (this is called a coordination of benefits). Should you neglect to disclose this to any of the parties (the clinic or your insurances), claims could process incorrectly. You will be responsible for any unpaid claims that are the result of a lack of coordination of benefits.
5. We highly recommend you also contact your insurance carrier and check into your coverage for physical therapy services. Do not assume that you will not owe anything if you have more than one insurance policy.
6. **The estimate provided at time of service is not an exact calculation of your actual costs** and does not reflect all of the terms, conditions, limitations, and exclusions that may apply to your coverage. Your actual costs will vary depending upon the specifics of your benefit plan and the services and supplies you receive.
7. If this injury is work related and a Workers Compensation claim has been initiated, we require that you provide us with a claim # to ensure payment of the account. This must be done on your first visit with us.
8. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. **It is our policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.**
9. Our office requires **a 24-hour notice for cancellation of appointments;** you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there may be a $35.00 charge for a missed appointment without notification to the office.
10. Payment is due at time of service unless you have signed a monthly payment contract through our Billing Office. Payments made on account will be applied to the oldest outstanding balance first. Unpaid balances may be assessed a finance charge.
11. We reserve the right to terminate services if payments are not made in a timely fashion.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Should you encounter problems making payments on time, we encourage you to contact us promptly for assistance in setting up a payment plan. If we do not receive payment from you according to agreement and/or the arranged payment plan notice we sent to you, you agree to be responsible for any expenses incurred in collecting the patient's account balance, including all fees, court costs, attorney fees and all other collection related expenses.

By signing below, patient/responsible party acknowledges that he/she has read, understands and hereby accepts the above obligations and agreements.

Patient Name: **Signature:** **Date:**

Information below is ***required for treatment of a minor or a patient who does not have their own power of attorney.***

*******PERSON SIGNING BELOW MUST FILL OUT ATTACHED GUARANTOR INFORMATION**********

Name of Parent or Legal Guardian: **Signature:**

Date:____

GUARANTOR INFORMATION

IF YOU ARE SIGNING OUR FINANCIAL POLICY OR INTAKE FORM AS THE PERSON OR LEGAL GUARDIAN OF THE PATIENT LISTED ON THIS FORM, WE MUST HAVE THE FOLLOWING INFORMATION:

Name of Parent or Legal Guardian: ______________________________

Male Female DOB:___________________________ SSN:___________________________

Mailing Address: __________________ City/State: __________________ Zip: __________

Phone: Home: __________________ Work: __________________ Cell: __________________

Email Address: ______________________________

Place of Employment: __________________ Occupation: __________________

Employment Address: __________________ City/State: __________________ Zip: __________

MISSED APPOINTMENT POLICY

We appreciate you greatly as our patient and strive to accomplish optimal results and success for you. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, please call our office and arrange for a make-up appointment within the same week. We reserve the right to charge most patients a $35 no-show fee for cancelling an appointment without 24-hour notice or a no-show to a scheduled appointment.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. Your physician will be informed that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

PHYSICAL THERAPY TREATMENT CONSENT

I request and consent to the physical therapy evaluation and treatment performed or directed by a licensed physical therapist or licensed physical therapist assistant of the company I understand that the physical therapists will evaluate and determine the appropriate treatment procedure/s specific to my presentation and condition. The treatment procedures will be in compliance with the state's physical therapy practice act and may include manual therapy techniques, such as spinal and extremity manipulation/ mobilization and instrument-assisted techniques (i.e. dry needling, cupping, ASTYM); neuromuscular re- education; therapeutic activities; therapeutic exercise; and modalities such as ultrasound, electrical stimulation, iontophoresis, and heat/cold therapy.

I understand that by participating in physical therapy there are potential risks to treatment that may include, but are not limited to fractures, disc injuries, cardiovascular issues, pneumothorax, bruising, increases in pain, burns, and nerve injury. It is not reasonable for the therapist or assistant to explain all risks at any particular visit, and I understand I have the right ask questions and to terminate any part of the physical therapy treatment at any time.

By signing below, I hereby acknowledge and agree that I have completely read and fully understand the Physical Therapy Treatment Consent and Missed Appointment Policy form. I have had the opportunity to inquire about its content and by signing below I agree to the above-mentioned procedures.

Patient Name: **Signature**: ____________________

Date: ____________________

Below required for treatment of a minor or patient who does not have their own power of attorney.

Name of Parent or Legal Guardian: **Signature**: ____________________

Date: ____________________

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Nutrition & Activity Questionnaire

Name:		Age:	

Current weight:	lbs.	Healthy weight goal:	lbs.

Bio Markers

Total Cholesterol:		BP:		A1C:		BMI:	

Nutritional Information

Describe your diet in one sentence:			
How many times per week are your meals home-cooked?		How many times perweek do you eat at restaurants or take out?	
Are there any foods you just don't like?		What is your favorite food?	

What did you eat yesterday?

Breakfast:	Lunch:	Dinner:
Anything else? (non-water drinks, candy, all snacks)	How much water do you drink per day? (glasses/oz)	

Activity Information

How would you describe your activity level?	Which type of activities do you enjoy?
If you participate in a fitness program, describe your activities, sessions per week, minutes per session, and level of exertion:	
If you can no longer enjoy the activity, which activities did you enjoy when you could move better?	
Are you interested in discussing and receiving helpful information about the details you provided on this form?	Yes Please ☐ No Thanks ☐

MOVE Better, FEEL Better, LIVE Longer.

PTA PHYSICAL THERAPY