

Patient Intake & Health History Form

Patient Information

First Name: _____		Last Name: _____		Middle Initial: _____	Gender: M or F
Address: _____		City: _____	State: _____	Zip Code: _____	
Preferred Phone H/C/Wk: _____		Phone H/C/Wk: _____			
Email Address: _____			Date of Birth: __-__-__	Last 4 SSN: _____	
Marital Status: Single/Married/Other					

Employer Information

Employer Name: _____		Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Student			
Employer Address: _____		City: _____	State: _____	Zip Code: _____	
Work Phone Number: _____		Patient Occupation: _____		Modified Duty: Y/N	

Emergency Contact

Contact Name: _____	Relationship to Patient: _____
Phone Number: _____	

Physician Information

Name of Referring Physician: _____	Phone Number: _____
Family Physician: _____	Phone Number: _____

Patient Goals

My Goals in coming to Physical Therapy are:	
To Get rid of my Pain _____	To Improve Sports Performance: _____
To Get Stronger _____	To Improve my Work abilities: _____
To Improve Range of motion _____	To get better with my home activities _____
Other: _____	

Additional Questions

Auto Related: Yes/No	Work Related: Yes/No	Accident Related: Yes/No
Body Part: _____	Right or Left	Date of Injury: _____
Mechanism Of Injury: _____		
Rate Your Pain: 0 _____ 5 _____ 10 _____	Current Pain Level: ____/10 Pain At Worst ____/10 Pain At Best: ____/10	
No Pain	Most Severe Pain	
Have you had diagnostic tests performed for this injury: Y/N MRI: Y/N X-Ray: Y/N Where were they performed: _____		

Are you currently receiving home health care services? Yes/No	Name of Agency: _____	Phone Number: _____
If Yes, what type of home health care services: _____		
Last date of service: _____		
Have you received PT, OT or Speech therapy services since the first of the year? Yes/No		

How did you hear about us?			
My Doctor referred me here _____	Previous Patient _____	Family/Friend _____	Their Name: _____
List Provided by my Doctor _____	Insurance List _____	Mailing Card _____	
Phone Book _____	Website _____	Other (explain) _____	

Patient Signature: _____ Date: _____

Medical History

	Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>

Medications:		
Drug:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I consent to Physical Therapy and Wellness Institute for treatments/procedures that are necessary or advisable for my care. I hereby authorize Physical Therapy and Wellness Institute to exchange with and/or release requested information on my medical care to my insurance carrier (s) and to:

___ Workers Compensation ___ Patient/Guardian ___ Attorney ___ Rehabilitation Intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due by my insurer to Physical Therapy & Wellness Institute. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Physical Therapy & Wellness Institute.

Patient's Signature

Date

I have read and understood Physical Therapy & Wellness Institute's privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.

Patient's Signature

Date

I have read and understand Physical Therapy & Wellness's billing and collection policies, The Financial Policy, cancellation and now show policies. I further understand that I may obtain a copy of this policy upon my request.

Patient's Signature

Date

Responsible Party's Signature (if patients is a minor)

Date

Employee's Signature

Date

Now the easy stuff:

Patient Agreement:
 I agree to attend when scheduled. (Cancellations affect 3 people – Your Therapist, the patients wanting appointments, and your recovery)
 I agree to be respectful towards other patient's privacy.
 I agree to give good effort in my rehabilitation program.

PTW Agreement:
 We agree to have staffing available to attend your needs.
 We agree to give you the privacy that you expect.
 We agree to provide you with quality Physical Therapy to help you achieve a higher level of performance at *your body repair stop*.

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Use and Disclosures: There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than by law or under emergency circumstances may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosure without Patient Acknowledgement of this Notice:

We will attempt in good faith to obtain your signed Acknowledgement that you received this notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan pre-certification of services or review of services for the purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, general administrative functions and patient newsletters. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclosure Without Acknowledgement or Authorization: There are certain circumstances under which we may use or disclose your medical information without first obtaining your acknowledgement or authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for use or disclosure: Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to the information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident or to educational authorities, without your written authorization.

Additional uses and disclosures: We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individual Rights: You have certain rights with respect to your medical record information as follows: You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations or restrictions involving your care or payment related to care. We are not required to agree to the restrictions; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. In addition, you have the right to request receipt of confidential communications.

FINANCIAL POLICY

We are committed to providing you with the best care possible. If you have medical insurance, we are anxious and pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard or Visa. All insurance identification cards must be submitted for confirmation on the first visit before treatment begins.

Returned checks or balances older than sixty (60) days may be subject to additional collection fees and interest charges of 1.5% per month. All balances that reach 90 days past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs in collecting the balance.

Any balance for past services must be paid in full before being seen in our office in the future.

Insurances

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. **You must realize, however, that your insurance is a contract between you, your employer if so provided and the insurance company. We are not a party to that contract except where we are under contract as preferred providers.**

Since we participate with several insurance companies, you must verify with the Office our status with your plan. We will be happy to help you process your insurance claim for reimbursement from companies with which we participate.

If we do participate with your insurance company, all services performed at our office will be submitted to them unless we have received prior notification of non-covered services. **All co-pays, co-insurance and deductible amounts are the patient's responsibility and will be billed to you by our office.**

Some insurance plans may require referrals for services. It is the patient's responsibility to obtain the referral prior to the time of service. If a referral is NOT presented at the time of service, the patient will be responsible for payment in full for services provided at that time. **All co-pays are due at the time of service.**

If we do not participate with your insurance company, we will not bill your insurance carrier and not accept payment from them as payment in full for services performed. Any balance not covered by the insurance company becomes the responsibility of the patient. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

In auto accident cases, we accept auto insurance payments including your benefits under PIP (Personal Injury Protection). It is your responsibility to provide us with this important information as well as your signature (and your attorney's) on the

Authorization and Assignment Form. After you have reached your maximum PIP benefit, you are responsible for any remaining balance. If other insurance may cover the remaining balance, it is your responsibility to provide all necessary cooperation and information to our office that will allow us to pursue reimbursement from that source.

Guarantee of Payment on Motor Vehicle Accident / Personal Injuries

If your motor vehicle or personal injury claim becomes a litigation case, then I, (patient name) _____ agree to name ***The Physical Therapy and Wellness Institute*** as part of the settlement and pay any outstanding balances in full. If your case reaches settlement and The Physical Therapy and Wellness Institute does not receive payment we retain the right to send your account to collections for payment in full.

In Worker's Compensation cases, We will send appropriate claim forms for services rendered on your behalf. If and when a claim is denied, we will expect payment from the patient within thirty (30) days of the receipt of denial by the carrier. If you have other insurance options that may cover these costs, we will assist you obtaining reimbursement from this alternate source if we are notified by you within the thirty (30) days following the original denial of coverage.

Please bear in mind that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as therapy providers, our relationship is with you, not with your insurance company. While the filing of a claim is a courtesy that we extend to our patients, **all charges are strictly your responsibility from the dates services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, it is your responsibility to contact us promptly for assistance in the management of your account.**

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH ABOVE. I AGREE TO THE TERMS OF THE FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY PTW (Physical Therapy & Wellness Institute) AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Patient Agreement for Services and Release of information

This agreement is between the Physical Therapy & Wellness Institute, Inc., (PTW) and _____ (the patient).

Because services are to provided to me by PTW, I agree to the following:

1. **Treatment Authorization:** Since my state of health requires the services of PTW, of my own free will, I agree to actively participate in these services such as assessments, treatments, personal care, and therapeutic exercises prescribed by my physician, and given by the Physical Therapy staff of PTW. I understand that PTW has specific policies, and that these policies include that services can be stopped at any time by my request, the request of my physician, and/or the decision of PTW. I agree to follow all the terms of these PTW policies.
2. **Non-Discrimination:** PTW and the patient agree that services are given without regard to race, color, sex, age, national origin, or handicap.
3. **Release of Information:** I give PTW my permission to give needed information from my records to any of my insurers and to all other agencies, institutions, or individuals from whom I have received health or social services for the release of information to PTW.
4. **Medicare-Title XVIII of the social security act:** I understand that I need to give information so that PTW can apply for and receive payment under this Medicare Act. By signing this, I certify that information given by me is correct.

Patient Agreement:

I agree to attend when scheduled.
I agree to be respectful towards other patient's privacy.
I agree to give good effort in my rehabilitation program.

PTW Agreement:

We agree to have staffing available to attend your needs.
We agree to give you the privacy that you expect.
We agree to provide you with quality Physical Therapy to help you achieve a higher level of performance at *your body repair stop*.

I am the patient, or the responsible party, signed below. I read and understood this agreement.