

New Patient Intake Forms

Demographics:

Name: _____ DOB: _____ Today's Date: _____

Email: _____ May We Email You Information: Yes / No

Address (Street/City/State/Zip): _____

Preferred Phone Number: _____ (Circle: Home Cell Work)

Secondary Phone Number: _____ (Circle: Home Cell Work)

May we leave a voice message at the above numbers? Yes / No

May we leave a text message at the above numbers? Yes / No

Age: _____ Height: _____ Weight: _____ Sex: _____ Handedness: Right / Left

Occupation: _____ Are you currently off work: Yes / No

Primary Care Physician: _____

Referred By: _____

Chief Complaint/Location of Injury: _____

Date/Place of Injury: _____ Date of Surgery/Type: _____

Accident: Yes / No - Workers' Comp: Yes / No - Legal: Yes / No

Diagnostic studies for your current condition: (X-ray, MRI, EMG, etc.): _____

Rate your pain (Average of last 72 hours): None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst

Describe your pain: Dull/Ache - Sharp/Stabbing - Pins/Needles - Shooting/Burning - Throbbing - Twinge - Numbness/Tingling - Other: _____

Is your pain constant: Yes / No

Is your condition: Getting better - Staying the same - Getting worse

Are you currently receiving therapy: _____

Have you had Therapy (PT/OT) in the last year: _____

Are you currently receiving any home health care services: _____

Medical History (Check all that apply)

- | | | |
|--|--|--|
| ☐ Allergies | ☐ DVT/Blood Clot | ☐ Pacemaker |
| ☐ Anemia | ☐ Falls | ☐ Pregnant |
| ☐ Anxiety | ☐ Fractures | ☐ Seizure/Epilepsy |
| ☐ Arthritis | ☐ Fainting/Dizzy | ☐ Sensitivity |
| ☐ Asthma | ☐ Headache | ☐ Heat/Cold |
| ☐ Blood Pressure (High/Low) | ☐ Hearing Loss | ☐ Shortness of Breath |
| ☐ Bruising | ☐ Heart Attack | ☐ Stroke |
| ☐ Cancer/Tumor | ☐ Heart Disease | ☐ Substance Abuse |
| ☐ Cardiac Condition | ☐ Hepatitis | ☐ Thyroid Condition |
| ☐ Cholesterol (High/Low) | ☐ Hernia | ☐ Tuberculosis |
| ☐ Concussion | ☐ HIV/AIDS | ☐ Urinary Condition |
| ☐ Cough | ☐ Infection | ☐ Vascular Condition |
| ☐ Depression | ☐ Kidney Conditions | ☐ Vision Loss |
| ☐ Diabetes | ☐ Metal Implants | ☐ Other: |
| | ☐ Osteopenia | |
| | ☐ Osteoporosis | |

If Yes to any of the above, please explain: _____

Past Surgical History? Yes / No

If yes, please list w/ dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Medication History - (Circle: Yes or No) - If Yes, List all current medications:

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for taking: _____

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Allergies: Do you have any Medication Allergies? If Yes, please list and explain:

Cancellation Policy

Please contact our office at least 24 hours in advance if any appointment cannot be kept. We recommend that you reschedule your appointment in order to remain on course to meet your rehabilitation goals.

If you are late to your appointment, circumstances may require that your appointment be shortened or rescheduled to another date and time.

You may be discharged from therapy if multiple (greater than two) appointments are missed without advanced notice (i.e. no-show). Depending on your insurance you may then need a new therapy prescription prior to returning to therapy. If your therapy is being covered by worker's compensation, then we are required to report any missed appointments.

Failure to cancel or reschedule 24 hours in advance of your appointment will result in a \$50.00 Fee Due Prior to Next Appointment.

Consent to Treatment & HIPPA Privacy Statement Medical Consent:

The undersigned hereby authorizes providers to render to patient physical therapy and wellness services (collectively referred to as "services") that the Provider (physical therapist) determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of services. The undersigned acknowledges that no guarantees have been made as to the results of assessment of treatment. Services rendered at PhysioHealth Physical Therapy, Inc are a combination of current best practices supported by literature and expert opinion.

Medical Records Release:

The Patient or the guarantor of the account hereby authorizes PhysioHealth Physical Therapy, Inc to release Patient's medical record (including any information furnished to Provider or obtained by Provider in connection with Patient's treatment) to any referring physician, insurance company, healthcare facility, or governmental agency (including the Social Security Administration or any of its intermediaries or carriers) requesting such information. Authorization is also given to the release of records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

Medical Insurance Benefits:

The undersigned hereby assigns to Provider all private medical insurance benefits (primary, secondary, and medi-gap providers) or other benefits to which Patient may be entitled for any services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.

Medicare and Medicaid Authorization:

I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct and I request payment of authorized benefits to be made on my behalf. I authorize the Provider to release to the Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information about me needed for Medicare claim, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished to me. I further state under both titles that I do not have any other insurance that is to be filed primary over my Medicare and/or Medicaid.

HIPAA Disclosure:

I understand PhysioHealth Physical Therapy, Inc will maintain my privacy as it is included in my patient rights. My information may be used for administrative, billing, and clinical purposes.

Patient Financial Policy:

To Our Valued Patients,

At PhysioHealth Physical Therapy, Inc we are committed to providing patients with the highest level of care. If you have medical insurance, we are committed to helping you receive your maximum allowable benefits. In order for us to achieve these goals we need your assistance and understanding of our payment policy. Payment for services is due at each visit. This includes any applicable deductibles, coinsurance, and copayments. At our facility we accept cash, check, and major credit cards (Visa and Mastercard).

Please review carefully:

1. **We cannot guarantee the benefits quoted are exact, and therefore you may receive a statement for additional balances due after the claim is paid by your insurer. You are responsible for all balances due as a result of this service.**
2. **We verify eligibility and obtain insurance benefit information as a courtesy to our patients, but there may be deductibles, plan limitations, etc that we are not aware of.**
3. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. These particular services, if any, are your responsibility.**
4. **PCP Authorizations: Some insurance plans require a PCP authorization/referral. It is the patient's responsibility to know this and obtain the referral from your PCP. If we do not have this on file and your insurance does not reimburse us for the visit charge, then you will be responsible for the visit(s).**
5. **Visit Limits: Some insurance plans have a limited number of visits. It is the patient's responsibility to know if you have a limited number of visits and if any have been used. Should you go over your visits and we do not get reimbursed, you will be responsible for those visit(s).**
6. **Please let us know if you have received occupational, physical, or speech therapy in the past year, as some insurance plans have limits on total visits. It is the patient's responsibility to know your visits. If you should go over your visits and your insurance provider denies payment, you will be responsible for the fees.**
7. **If you schedule two services (PT/OT/ST/Chiropractic) on the same day at two different facilities and your insurance does not cover the services, then it is your responsibility for the fees incurred at our facility.**
8. **Worker's Compensation: Please check with our staff to ensure all authorizations have been obtained.**
9. **A "Self-Pay" Option is available in the event we do not accept your insurance, your benefits are exhausted, or you do not have coverage. Please call our office and ask for more information (781-859-4189)**
10. **Supplies: All insurances excluding some worker's compensation plans do not reimburse for supplies. The patient in this case is responsible for all supplies.**

I have read and understand all of the above policies and agree to them:

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____