

PATIENT INTAKE FORM

PLEASE FILL OUT COMPLETELY AND CLEARLY

Date: _____ Patient's Legal Name: _____

Nickname: _____ Gender: _____ DOB: _____ SSN: _____

Mailing Address: _____ City/State/Zip: _____

Main Phone: _____ Cell: _____ Email Address: _____

Employer: _____ Occupation: _____

Address: _____ Phone#: _____

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):

Date of Injury: _____	Claim #: _____
Insurance Company: _____	Phone #: _____
Address: _____	State: _____ Zip: _____
Adjuster/Case Manager: _____	
Is an attorney involved? [] Yes [] No - Attorney Name/Phone#: _____	

Have you had any therapy in the *past 12 months*? [] PT [] OT [] Speech [] Chiropractic [] Cardiac/Pulmonary or [] 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.

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PATIENT HEALTH SUMMARY

Name: _____ Age: _____ M F DOB: _____

Height _____ Weight _____ 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 a fall 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: _____

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 If no, where? _____

Was it for the *same injury*? [] Yes [] No

Please check all that apply to you:

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

Are you currently pregnant? Yes _____ No _____

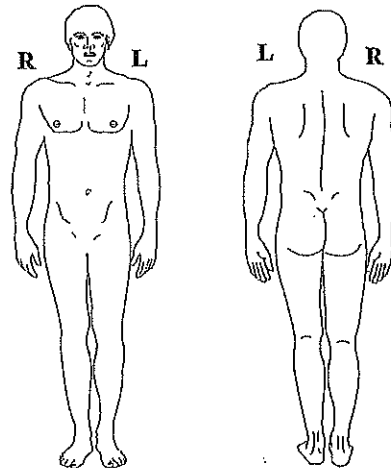
Is there anything else you feel we should be aware of? (fractures, other medical conditions)

List surgeries you have had:

Circle the number that best describes your status:

Please shade in the areas where you are experiencing pain:

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



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: _____

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/OCCUPATIONAL THERAPY TREATMENT CONSENT

I request and consent to the physical/occupational therapy evaluation and treatment performed or directed by a licensed physical/occupational therapist or licensed physical/occupational 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/Occupational 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: _____

Media Release

This release form, if signed, will **not** be shared and will **only** be used for Lonoke Physical Therapy, Inc. purposes. Those purposes include, but are not limited to, our newsletters, advertisements, Facebook and website. The purpose of this Media Release Form is to ensure no one's photo, video or other medium is released without the patient's consent. Please check your preference below, then sign and date the form, where indicated.

_____ **Agree** _____ **Disagree**

I, _____, (please print name) hereby give Lonoke Physical Therapy, Inc. permission to publish my name and/or photo in, but not limited to newsletters, ads, Facebook and website and any other marketing promotional pieces.

Patient or Guardian signature: _____ **Date:** _____ / _____ / _____