INTAKE FORM

elite PHYSICAL THERAPY

PATIENT INFORMATION

First Name: Last Name: Middle Initial: Date:

Address: City: State: Zip:

Birth date: Age: ☐ Male ☐ Female S.S. #:

Home Phone: Alternative Phone (Cell, Work): Spouse:

E-mail Address: Height: Weight:

Chose Clinic Because: ☐ Doctor ☐ Insurance ☐ Family/Friend ☐ Former Patient ☐ Yellow Pages ☐ Other

Whom may we thank for your referral:

WORK INFORMATION

Employer: Work Phone: Extension:

Occupation: Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Doctor: Referring Doctor Phone:

Regular Doctor/PCP: Regular Doctor/PCP Phone:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different): Birth date:

ID #: Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name: Birth date :

ID #: Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INSURANCE INFORMATION FOR BACKUP)

Insurance Name: Auto/Workers Comp:

Adjuster/Claim Manager: Phone: Extension:

Address: City: State: Zip:

Claim #: Accident Date: Cause:

ATTORNEY INFORMATION

Name: Law Firm: Phone:

Address: City: State: Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:

Relationship to Patient: Home Phone: Work Phone:

I authorize my insurance benefits be paid directly to Elite Physical Therapy I understand that I am financially responsible for any balance. I also authorize Elite Physical Therapy to release any information required to process my claims.

Patient/Guardian Signature Date

PATIENT MEDICAL HISTORY

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To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank You!

Exercise routine when healthy: _____

_____

Please check if you are currently seeing any of the following health care professionals:

- ☐ Medical Doctor
- ☐ Psychiatrist/Psychologist
- ☐ Osteopath
- ☐ Occupational Therapist
- ☐ Dentist
- ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

_____

_____

_____

Have you **ever** been diagnosed as having any of the following conditions?

- ☐ Cancer — If YES, describe what kind:_____
- ☐ Heart problems
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Emphysema/Bronchitis
- ☐ Chemical dependency
- ☐ Multiple sclerosis
- ☐ Other arthritic conditions
- ☐ Diabetes
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Anemia
- ☐ Epilepsy
- ☐ Allergies
- ☐ Depression
- ☐ Hepatitis
- ☐ Stroke
- ☐ Kidney disease
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ AIDS/HIV:

Are you currently pregnant? ☐ Yes ☐ No If YES, what is your due date:_____

Have you recently experienced unexplained weight loss or gain? ☐ Yes ☐ No

Have you experienced loss of bowel or bladder control? ☐ Yes ☐ No

Are you experiencing any of the following?

- ☐ Dizziness
- ☐ Difficulty speaking
- ☐ Difficulty Swallowing
- ☐ Drop Attacks
- ☐ Double Vision

List any other information which would assist us with your care: _____

_____

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date **Surgery/Hospitalization** **Reason**

_____

_____

_____

Please list any x-rays or imaging that you have had done:_____

_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date _____ **Injury** _____

Date _____ **Injury** _____

Date _____ **Injury** _____

Date _____ **Injury** _____

Date _____ **Injury** _____

Date _____ **Injury** _____

Have you traveled out the country within the last three weeks: Yes No

PATIENT MEDICAL HISTORY (CONTINUED)

elite PHYSICAL THERAPY

Which of the following **over-the counter** medications have you taken **in the last week?**

- ☐ Aspirin
- ☐ Tylenol
- ☐ Advil/Motrin/Ibuprofen
- ☐ Laxatives
- ☐ Decongestants
- ☐ Antihistamines
- ☐ Antacid
- ☐ Vitamins/mineral supplements
- ☐ Other _____

Please list any **prescription** medication you are currently taking, including pills, injections, and/or skin patches:

_____

_____

_____

Please list the activities that aggravate your pain? _____

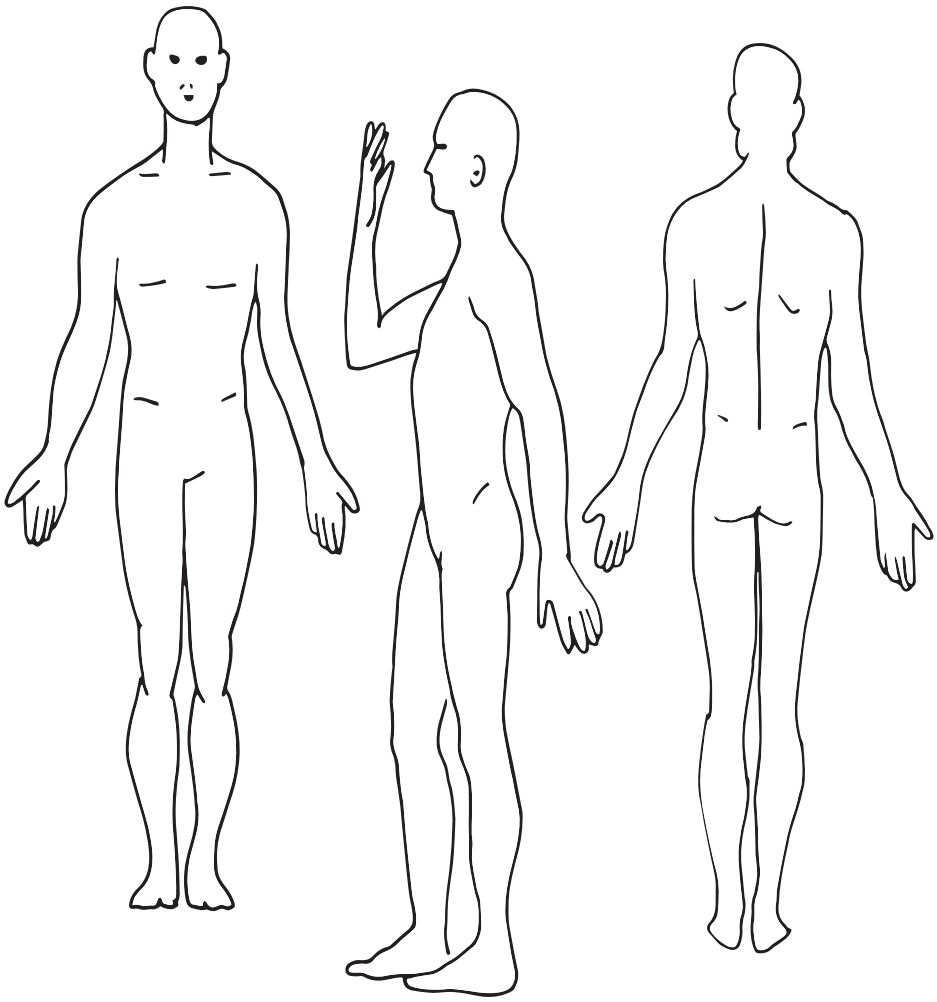
_____

_____

Please list your current strategies to help alleviate your pain?_____

_____

_____



Please indicate areas of pain and discomfort (on the figures above) using the following numbers:

1 = Pain
2 = Numbness, no feeling at all
3 = Tingling, asleep, abnormal feeling

Please rate your pain on a scale of 0 to 10: _____ (0 being no pain, 10 being the worst pain)

PAYMENT POLICY

elite PHYSICAL THERAPY

Thank you for choosing us as your physical therapy provider. Our goal is to provide high quality, thorough, effective treatment and care to each and every patient. In return, we ask each patient to accept responsibility for paying the fees for his or her treatment. Please read through this short policy statement and sign your name to indicate your acceptance. At the time you receive treatment, please pay the portion of your fees which is not covered by insurance. Payment may be made by check, Visa, MasterCard, debit card (with Visa or MasterCard logo), or in cash.

We will verify your insurance benefits before your first appointment. However, verification of eligibility is not a guarantee of payment. I understand that I am responsible for any fees not covered by my insurance. I also understand that it is my responsibility to check my insurance policy to be aware of any limitations (such as visit limit) or exclusions.

We'll make a good faith effort to obtain payment from your insurer according to the information you give us, and in turn we'll expect you to pay whatever remaining balance exists when sixty days have gone by since your treatment.

If payment is not made on each appointment or if a remaining balance is not paid after being presented with a bill, we may decline to schedule additional treatments until you have paid for the services already provided.

Missed appointments are a problem for us. If you realize that you won't be able to keep your appointment, please let us know as soon as possible. If you miss any of your appointments without notifying us at least 24 hours ahead, we will charge you $50.00 missed appointment fee.

Thank you for the time you've taken to read through this sheet. We ask that you sign your name below to acknowledge our payment policy.

Sign: _____ Date: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

elite PHYSICAL THERAPY

I understand that **Elite Physical Therapy** (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decision about and plan for my care and treatment;
- Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business function that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will bee posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of the clinic's Notice of Privacy Practices.

Patient Signature: _____ Date:_____

Patient Representative Signature: _____ Date:_____
Description of Representative's Authority: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtain because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)_____