



NEW PATIENT INTAKE: AUB HOL HOP

DATE OF APPOINTMENT: _____ TIME: _____ PT: _____

PATIENTS NAME: _____ DOB: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME#: _____ CELL#: _____ WORK#: _____

S.S.#: _____ MARITAL STATUS: _____ E-MAIL: _____

Name of Minor's Parent: _____ Emergency Contact: _____ Phone #: _____

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN: _____ PHONE#: _____

REFERRING PHYSICIAN: _____ PHONE#: _____

DIAGNOSIS: _____ ICD9#: _____

HOW DID YOU HEAR ABOUT US?: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SUBSCRIBER I.D.#: _____

PRIMARY SUBSCRIBER: _____ INSURED S.S.#: _____

SECONDARY INSURANCE: _____ SUBSCRIBER I.D.#: _____

CIRCLE ONE: W/C MVA PI

DATE OF INJURY: _____ CLAIM/FILE#: _____

COMPANY CLAIMS WILL BE BILLED TO: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

ADJUSTER NAME: _____ ADJUSTER PHONE #: _____ EXT: _____

INITIAL EVALUATION APPROVED: YES NO

UR FAX#: _____ UR PHONE #: _____

OTHER INFORMATION: _____

ATTORNEY INFORMATION: SEE LIEN

NAME: _____ PHONE#: _____ FAX#: _____

ADDRESS: _____ CITY/STATE/ZIP: _____



FINANCIAL AGREEMENT

1. I understand that health insurances, worker's compensation, motor vehicle/personal injury and other third party payer policies are arrangements by and between insurance carriers and the subscriber. **Furthermore, I understand that it is my responsibility to be aware of the benefits available to me through my insurance carrier and that it is in my best interest to call my health insurance company and verify my individual benefits.** I understand that I am responsible for acquiring a **prescription** for physical therapy from my **PCP and/or REFERRING PHYSICIAN**. I also understand that I am responsible for securing a **REFERRAL, PRE-AUTHORIZATION and/or CLAIM NUMBER** from my **HEALTH INSURANCE CARRIER, WORKER'S COMPENSATION CARRIER and/or MOTOR VEHICLE/PERSONAL INJURY THIRD PARTY PAYER**. If this information is not provided to **Physical Therapy Innovations, Inc. (hereinafter PTI)** at the time of my **FIRST VISIT**, I agree that I am responsible to **pay out-of-pocket for the services rendered to me** until such time the information (referral, claim number, pre-authorization and prescription) is provided to **PTI**.
2. I authorize the release of any and all medically necessary information to process all claims related to services rendered at PTI.
3. I authorize payment of medical benefits directly to **PTI** for professional services rendered.
4. I understand that **payment** for all services rendered to me is ultimately my **individual** responsibility.
 - **Co-payments and payments toward deductibles/co-insurances** are due and payable at time of service.
 - Any and all unpaid balances for professional services are due within **30 days of discharge** from services at **PTI**. If payment is **NOT received within 30 days, all balances** are subject to an **18% finance charge annually**.
5. **PTI requires a 24 hour cancellation notice. There is a \$35.00 service fee for NO-SHOWS or CANCELLATIONS without proper notice. This charge is NOT covered by your medical insurance and is billed directly to the client and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care. _____(patient initials).**
6. Your appointment may be cancelled and you may be charged for the cost of your treatment session, if you are more than 10 minutes late for your appointment.
7. There is a \$35.00 returned check fee.
8. **If there are any changes to your Health Insurance Benefits or Carrier, it is your responsibility to notify and update PTI within 10 business days.**
9. **If your injury is related to a Motor Vehicle Accident, Personal Injury or a Worker's Compensation Injury, it is your responsibility to inform PTI.**
10. **It is your responsibility to inform PTI if you have secondary insurance.**

(Check if applicable) **CONSENT TO TREAT A MINOR** - I the parent/guardian of _____ authorize **PTI** to treat the minor patient named above while I am not present.

By signing this form, I acknowledge that I have reviewed and agree to PTI's use and disclosure of my private healthcare information (HIPAA) for treatment, payment and health care operations.

I have read and agree with all the provisions within **PTI's financial agreement**. I further acknowledge that all the information given, whether oral or written by me to Physical Therapy Innovations, Inc. is true.

PATIENT SIGNATURE

RESPONSIBLE PARTY SIGNATURE

___/___/___
DATE

Signature of Authorized Clinic Representative

___/___/___
Date



CONDITIONS AND CONSENT FOR PHYSICAL THERAPY

Informed Consent for Treatment : The term “informed consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial evaluation concerning the treatment and options available for my condition.

Potential Benefits: These may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential Risks: I understand I may experience an increase in my current level of pain and discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside within 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist at Physical Therapy Innovations Inc., cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her/his opinions regarding potential results from physical therapy treatment for my condition and will discuss treatment options with me. This discussion will occur at my initial evaluation and be ongoing throughout my care at Physical Therapy Innovations.

Alternatives: If I do not wish to participate in physical therapy, I will discuss my medical, surgical or pharmacological alternatives with my physician.

I agree to discuss any questions I have regarding the physical therapy evaluation and treatment of my diagnosis with my physical therapist.

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

PRINTED PATIENT NAME

PATIENT/PARENT/GUARDIAN SIGNATURE

DATE

THERAPIST SIGNATURE

DATE

Patient Name: _____

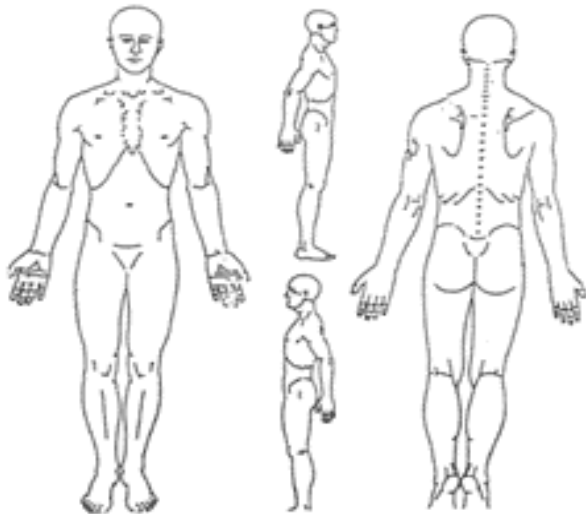
Pain Scale

Date: _____

1. Please rate your pain with 0 as No Pain and 10 as Unbearable for:

Pain at its WORST _____
 Pain at its BEST _____
 Pain CURRENTLY (TODAY) _____

Indicate where you have pain on the diagram



2. How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

3. Type of Pain:

- | | |
|---------------------------------|--------------------------------|
| <input type="radio"/> Sharp | <input type="radio"/> Numb |
| <input type="radio"/> Shooting | <input type="radio"/> Burning |
| <input type="radio"/> Dull Ache | <input type="radio"/> Tingling |

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. When did your symptoms begin?

6. How did your symptoms begin?

7. What tests have you had for your symptoms and when were they performed?

- X-RAYS: date taken: _____
- MRI: date taken: _____
- CT SCAN: date taken: _____
- OTHER: date taken: _____

9. Have you received Physical Therapy treatment this year? YES NO

10. If so how many visits: _____

For what diagnosis: _____

11. Who have you seen for your current symptoms?

- No One
- Chiropractor
- Medical Doctor
- Physical Therapist
- Other

12. What is your occupation?

13. What sports, exercise, or physical activities do you regularly participate in?

