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Patient Intake Form

Name: _____ _____ _____
First *Last* *MI*

Date of Birth: _____ Email: _____
Month/Day/Year

Home Address: _____ _____ _____ _____
Street/Apt # *City* *State* *Zip*

Phone Numbers: _____ _____
Preferred *Secondary*

Employer Name: _____ Work Address: _____
If student, retired, or unemployed, please indicate above. *Street, City*

Emergency Contact: _____ _____ _____
Name *Relationship* *Phone Number*

Prescribing Physician:
(If you have one) *Name* *Office Name* *Phone Number*

Primary Care Physician: _____ _____
Name *Phone Number*

How did you hear about us?

- ☐ Prescribing Physician
- ☐ Someone Else: _____
- ☐ Self, If self, please select below:
  - ☐ Clinic Website
  - ☐ Facebook
  - ☐ Google
  - ☐ Therapydia
  - ☐ Yelp
  - ☐ Other Website: _____
  - ☐ Follow-Up Visit/Repeat Patient
  - ☐ Clinic Storefront
  - ☐ Advertisement
  - ☐ Direct Mail
  - ☐ Event: _____

Your Goals

What are your goals for treatment? _____

Is there anything else you would like to ask your PT? _____

Patient/Guardian Signature: _____ **Date:** _____

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Medical History

Sex: _____ Preferred Pronoun: _____ Height: _____ Weight: _____

Type of Injury: _____ Onset/Injury Date: _____

Did your injury occur as a result of an accident? ☐ YES ☐ NO If yes, please select: ☐ WORK ☐ AUTO

Previous treatment for this injury: _____

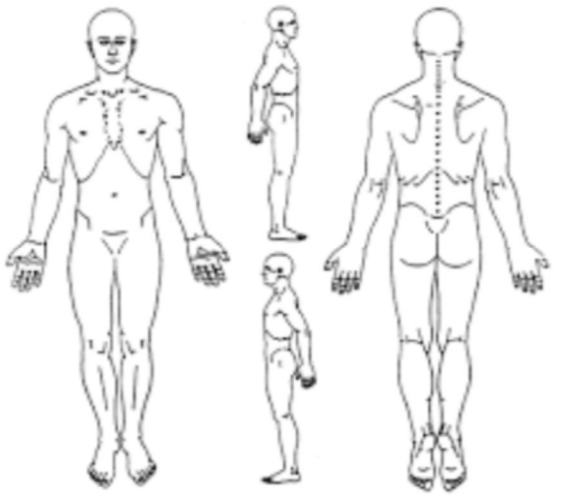
Have you had physical therapy treatment this year? ☐ YES ☐ NO If yes, how many visits: _____

Did you have surgery recently? ☐ YES ☐ NO If yes, procedure type and date: _____

Do you have pain that keeps you up at night? ☐ YES ☐ NO Recent weight loss/gain of 10+lbs? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO If yes, how far along: _____ *High Risk Pregnancy? ☐ YES ☐ NO

Is travel a significant part of your job? ☐ YES ☐ NO If yes, how frequently do you travel? _____



Please mark on the body chart where you are experiencing pain, and use the following options below to describe your pain.

XXX	= sharp/stabbing pain
/////	= numbness/tingling
^^^	= burning pain
OOO	= dull/aching pain
⟶	= shooting pain

Pain Rating 0-10
0 = no pain and 10 = severe pain

Current Pain: _____

Best Pain: _____

Worst Pain: _____

Please list any recent imaging:

X ray Date: _____ CT Scan Date: _____

MRI Date: _____ Other: _____

Have you recently noticed:

- ☐ Significant Weight Change
- ☐ Significant Weakness
- ☐ Fatigue
- ☐ Nausea/Vomiting
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Cramping
- ☐ Vision/Hearing Changes

Do you have or ever had:

- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes (Type 1)
- ☐ Diabetes (Type 2)
- ☐ Fractures
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Allergies _____
- ☐ Emotional/Psychological _____ _____
- ☐ Chemical Dependency: _____ _____
- ☐ Other: _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your strength? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your flexibility? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently taking medications? ☐ YES ☐ NO

If yes, please list: _____

Patient/Guardian Signature: _____ **Date:** _____

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Office Policy

CONSENT FOR TREATMENT: I hereby agree and give my consent for Therapydia to provide physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. This consent is intended as a waiver of liability for such treatment except acts of negligence. _____(initial)

PARENTAL CONSENT FOR TREATMENT (UNDER 18):
As parent and/or legal guardian of _____, I authorize Therapydia to treat while I am not present.

Patient/Guardian Signature: _____ **Date:** _____

LATE ARRIVALS: Arriving 10 or more minutes late to a 30 minute appointment will be considered a no-show and will be subject to a fee of $70. Arriving 15 or more minutes late to a 40+ minute appointment will be considered a no-show and will be subject to a fee of $70. _____(initial)

PAYMENT DUE AT TIME OF SERVICE: "I understand that payment of deductible, co-payment or co-insurance is due at the time of service." Our office will provide you with a QUOTE of benefits, however, we cannot guarantee your benefits. Please note we have a return check fee of $35 dollars. We will collect your copay/coinsurance at each visit. In addition, Therapydia will provide a current account balance at each visit that may be paid by credit card, check or cash. You will also receive a monthly account statement. Therapydia stores credit card information securely and will automatically charge balances 30 days after you've received your first statement. If you have questions regarding your balance, please call our office manager as soon as possible. If you have a balance more than 60 days past due, you will be contacted by our billing company as a reminder to pay your bill. If we have made multiple attempts to reach you and you have taken no action to pay your bill, your overdue balance may be sent to collections. _____(initial)

ASSIGNMENT OF BENEFITS: I understand and authorize the release of medical information to file health insurance claims for me by Therapydia. I also authorize my insurance provider(s) to pay Therapydia directly. _____(initial)

INSURANCE BENEFITS: It is your responsibility to know your benefit information and you are ultimately financially responsible for all services rendered to you. As a courtesy, we will call to verify coverage prior to your first appointment and will verbally summarize this information, if you have provided your insurance information to our office. We will also provide a written summary at your first visit. This is only an explanation of coverage obtained from your insurance company and is not a guarantee of coverage. If the information provided by your insurance company is inaccurate or the insurance company changes its coverage, you will be financially responsible for payment for services and any charges not covered by your insurance plan. You further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of your treatments unless agreed to in writing by yourself and a representative of Therapydia. Please note that what we collect in the office may only be a portion of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collected in the office, you will receive a statement from our billing company to be paid in full within 30 days. If your statement is not paid within 30 days, your balance will be automatically charged to the credit card provided. If your account is deferred to a collection agency, you agree to pay all collection costs incurred. _____(initial)

BILLING FOR WORKERS' COMPENSATION OR AUTO POLICY: Therapydia will only bill your auto policy if one exists for the injury listed. We can bill your commercial insurance only if a claim is reported to the subrogation department of your carrier and it is provided to us in writing that this has been done. We do not accept liens and do not bill third part insurance.

SELF-PAY: For clients without insurance or who wish to submit to their insurance directly, Therapydia offers a time of service discount. While rates are subject to change, advance notice will be provided.

I have read and understand the above information and I understand my responsibility for the payment of my account.

Patient/Guardian Signature: _____ **Date:** _____

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.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may use medical information about you to provide you with medical treatment or services.

Payment: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party.

Health Care Operations: We may use and disclose health information about you for operations of our health care practice.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care.

Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Worker's Compensation: We may release medical information about you for workers' compensation or similar programs.

Public Health Risks: We may disclose medical information about you for public health activities.
Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.

Law Enforcement: We may release medical information if asked to do so by law enforcement officials.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Your Right to Inspect and Copy: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed.

Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.

Your Right to an Accounting of Disclosures: You have the right to request in writing, a list of accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request.

Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.

Your Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice, and will post the current notice in our facility.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Security of the Department of Health and Human Services.

Other uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Therapydia is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either electronically or on paper.

If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it. If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below.

Waiver (Receive HIPAA Electronically)

I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice. I am aware that this Notice is available to me online at Therapydia's website, www.therapydia.com, and I choose to receive such Notice electronically. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

Acknowledgement (Receive HIPAA Paper Copy)

I, the undersigned, acknowledge with my signature that I have received a paper copy of the abovementioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

CREDIT CARD ON-FILE WAIVER

This waiver acknowledges Therapydia's Payment Policy and our right to refuse future service to patients who do not follow the policy or refuse to pay outstanding balances including late cancellation fees of $70 per occurrence.

By signing below, a patient who does not keep a credit card on file, and who does not adhere to our late cancellation policy, is confirming their intention to promptly pay all outstanding balances, late cancellation, and no-show fees. The patient also acknowledges that if prompt payment is not received, Therapydia reserves the right to refuse future treatment until all outstanding balances are paid and a valid credit card is provided to keep on file.

Patient Signature: _____

Patient Printed Name: _____

Date: _____