PATIENT INTAKE FORM

EXPERIENCE PHYSICAL THERAPY

Appt ___ /___/ ___ @ ___:___

Patient Name (as it appears on ins. Card)_____ **DOB**_____

Patient address_____

Email_____ **Phone number**_____

DX_____ REF MD_____ AUTO RELATED? Y OR N

Currently in Home Health Y or N Has Patient had PT the year? Y or N Approx. # of visits_____

Primary Insurance_____ **Plan**_____

ID#_____ **Group #**_____

Policy Holder Name_____ **Policy Holder DOB**_____

Relationship (circle one) **Self** **Spouse** **Child** **Other**_____

Claims Address_____

Insurance Phone #_____

Secondary Insurance_____ **Plan**_____

ID#_____ **Group #**_____

Policy Holder Name_____ **Policy Holder DOB**_____

Relationship (circle one) Self Spouse Child Other_____

Claims Address_____

Insurance Phone #_____

Emergency Contact Name_____

Phone #_____ **Relationship**_____

I, the undersigned, do hereby agree and give my consent for Experience Physical Therapy to furnish medical care and treatment to the patient named above considered necessary and proper in diagnosing or treating his/her physical condition.
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.
I authorize release of information requested by my insurance plan for payment.
(You have the right to refuse to sign this acknowledgment if you so choose)

Patient (or guardian) **Signature**_____ **Date**_____

(for staff) Intake Complete by_____ Date_____

EXPERIENCE
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Name: _____ Date: _____ Date of Surgery or Injury: _____

Referring Physician: _____ Family Physician: _____

Height:_____ft_____in Weight:_____lbs **(this information is required for insurance reporting purposes)**

Current Medication list? _____

Current Pain Level (circle) 1 2 3 4 5 6 7 8 9 10 Have you had PT before? Y or N

Have you had any of the following Medical or Rehabilitative Services for ***THIS INJURY/EPISODE?***

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other: _____

Do You Have or Have You Ever Had Any of the Following?

	YES	NO		YES	NO
Asthma, Bronchitis	___	___	Severe or frequent headaches	___	___
Angina	___	___	Emphysema	___	___
Shortness of breath/chest pain	___	___	Vision or hearing difficulties	___	___
Coronary Heart Disease	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight loss/Energy loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemo/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/ Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you pregnant?	___	___
Emotional/Psychological Dx	___	___	Do you use Tobacco?	___	___

Patient/Guardian Signature: _____Date: _____

EXPERIENCE
PHYSICAL THERAPY

FINANCIAL POLICY/AGREEMENT

Please call your insurance carrier so that you can better understand your benefits. Although our office does verify coverage, online services only provide limited information. While we try to obtain accurate insurance benefits, we are occasionally given incorrect information. **If this occurs, you are responsible for any difference between what was quoted by your insurance company and what was actually paid.** If your insurance company requires you to have a referral or authorization for physical therapy, please verify with our front office that a current referral or authorization is on file. Many plans require authorization numbers for physical therapy visits. Our office will put forth as much effort as possible to help obtain these documents, however, **the patient is ultimately responsible for any resulting costs that may be associated with your visits.** It is your responsibility to know which insurance is your primary carrier and which is your secondary. We rely on the information you provide. Your signature below further verifies that you have not joined an HMO or other entity in which your Medicare/all other insurance benefits have been relinquished.

THE PATIENT IS ACCOUNTABLE FOR UNDERSTANDING THEIR INSURANCE BENEFITS, VERIFYING NECESSARY REFERRALS/AUTHORIZATIONS ARE ON FILE, AND PAYING SUSEQUENT OUT OF POCKET EXPENSES. COPAYS AND CO-INSURANCE PAYMENTS ARE DUE AT TIME OF SERVICE.

We have been informed that you have the following estimated responsibility:

Primary Insurance Carrier: _____ Copay (if applicable): _____

Secondary Insurance: _____

Prior Authorization Required: Y or N Number of visits approved: _____

Start Date: _____ End Date: _____

Annual Deductible	Amount Remaining	Average cost per visit **until deductible is met**	Coinsurance %	Payment per visit **after deductible is met**

THE AMOUNT ABOVE IS BASED OFF AVERAGE MARKET COSTS PARTICULAR TO YOUR INSURANCE PLAN, THIS IS NOT AN EXACT AMOUNT. IF YOU HAVE A DEDUCTIBLE AND/OR A CO-INSURANCE PLAN, YOUR FINAL STATEMENT MAY REFLECT A **BALANCE DUE** OR A **CREDIT** AT THE END OF ALL SERVICES AFTER CLAIMS HAVE PROCESSED.

By signing below, I agree to pay the amount written above at the time of service and I understand that I am responsible for any balance due after my treatment plan.

Patient Name: _____ **Date:** _____

Patient Signature: _____

EXPERIENCE
PHYSICAL THERAPY

CANCELLATION POLICY

There is a **$25.00** charge of any appointments that are cancelled with less than 24 hours advanced notice or for failing to arrive for an appointment without notice.
It is important to note that we pride ourselves in helping people get better. It is impossible to do so if you do not keep your appointments. Help yourself and us succeed by keeping your appointments.

Signature: _____ **Date:** _____

HIPAA PRIVACY NOTICE AND PATIENT RIGHTS ACKNOWLEDGEMENTS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain **privacy rights** regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I also acknowledge that I have been given the opportunity to review my patient rights which includes treatment without discrimination or exclusion based on race, color, national origin, age, disability, sex, religion or any other protected status. I also understand that I have the right to be provided interpretation services, both verbal and in writing during my treatment.

I understand that I have the right to file a grievance with Experience Physical Therapy's Compliance Officer or with the U.S Department of Health and Human Services, Office of Civil Rights if I believe that Experience Physical Therapy has failed to provide these services or had discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Patient Name (print): _____

Signature of Patient or Responsible Party: _____

Relationship to Patient: _____ **Date:** _____