



INTAKE FORM

Date: _____

Employee: _____

Full Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Preferred Pronouns: _____ Social Sec. #: _____

Address: _____ City/State/Zip: _____

Cell Phone: _____ Email: _____

Home Phone: _____ Appointment Reminders: Text Email None

Emergency Contact: _____ Contact Phone: _____

Referring Physician: _____ Primary Physician: _____

How did you hear about us? Friend/Family Internet Facebook Advertisement Other: _____

STRESS Level: low 1 ---- 2 ---- 3 ---- 4 ---- 5 high What is the main cause? _____

NUTRITION: What is your level of nutrition knowledge? none a little medium a lot

ACTIVITY: How often are you active? Frequency: _____ Duration: _____

What is an activity that you really enjoy doing? _____

FITNESS Goals: increase strength & stamina lose weight body toning increase flexibility & mobility

Other: _____

IMPORTANT RULES & POLICIES Please initial next to each.

- 1. _____ Late Policy: If you are more than 10 minutes late to your appointment, you may be rescheduled or asked to wait for the next available time slot.
2. _____ 24-HOUR advance notice is required for changes to an appointment, otherwise a \$30 fee may apply.
3. _____ Co-pays and/or deductibles are due prior to treatment.
4. _____ Not showing for an appointment without notice, will result in a \$30 fee.
5. _____ Cell phones must be shut off or silent. If you need to take a phone call, you may be asked to step outside for the duration. Phone calls during appointments may result in cancellation of appointment.
6. _____ Children must be supervised at all times unless they are capable of remaining in the waiting area, without disruption, for the full appointment time.
7. _____ We request that you verify your insurance benefits in addition to any verification done by Physio. It is important that our clients are educated on their insurance coverage.
8. _____ If you are experiencing any financial hardship, please notify us immediately so we can do our best to create a payment program that is feasible.
9. _____ If for any reason you are not satisfied with the care received, please let us know! Speak to the office manager, or reach out to 828.348.1780

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Physio Inc. and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Physio, Inc., and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Physio, Inc., or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Physio, Inc. and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Physio, Inc.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE PHYSIO PHYSICAL THERAPY & WELLNESS FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: _____

Parent/Guardian Signature: _____

Signature: _____ Date: _____

Date: _____

Employee: _____

Full Name: _____ Age: _____

Occupation: _____ Are you working now? Yes No

Where is your pain/problem? _____

Please indicate the following on the body to the right using the designated symbols:

- Stabbing Pins & Needles Achy
 Burning Numbness Other: _____

What caused your pain/problem?

When did it start?

On the scale, circle your worst pain level in the last couple of days:

None 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 **Severe (Emergency Room)**

How would you rate your ability to perform activities associated with your job? (If applicable.)

Unable to Perform 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 **No Problems**

How would you rate your ability to perform routine daily activities?

Unable to Perform 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 **No Problems**

Have you ever had this same (or similar) pain/problem before? No Yes _____

List one activity that you are unable to do that you absolutely want to be able to do again? _____

How optimistic are you that you'll get better? Please circle one. **Not at all** --- Mildly Optimistic --- Fairly --- Very Optimistic --- **Extremely**

Over the next 30 days, how many hours per week will you commit to getting better? _____

MEDICAL HISTORY

List all past surgeries with dates:

List any medications you are taking:

Check off any other conditions, allergies, chronic conditions, or precautions:

- | | | | | | | |
|--|---|---|--|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Muscular Disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> MRSA | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Disease |

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/ therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient/Guardian Signature

Date



Informed Consent and Policies Agreement

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

- 1) Does your condition interfere with the quality of your life?
- 2) Does your condition interfere with your ability to perform work or daily activities?
- 3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
- 4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
- 5) Are there specific goals set that are measurable and trackable?

If the above criteria are not met, you are welcome to participate in our elective services such as SmartLaser, massage, myofascial treatments, fitness/exercise training, ASTYM, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late

Please refer to the Intake Registration Form.

Authorization for Release of Records

Assignment of Benefits (for insurance patients)

Please refer to the Assignment of Benefits form.

Results

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefits and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents

If the patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Method of Contact & Image Release

I hereby give my consent for Physio, Inc. (Physio) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

- Call my home or other alternative location and leave a message on voicemail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient billing statements.
- Contact me by phone, mail, text or email to participate in marketing events, pertinent products or services offered by Physio.
- Use any photos or videos of me for promotional purposes on the internet or within the office.
- E-mail, mail or text message to my home, or other alternative location any, items that assist the practice in carrying out TPO, such as appointment reminders, patient billing statements, home exercise programs or reminders and updates from my therapist and their team.
- I have the right to request that Physio Physical Therapy & Wellness restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Physio to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Physio may decline to provide treatment to me.

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to the patient/caretaker to inform the therapist/staff about any health problems or allergies the patient may have. The patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries. Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration

The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

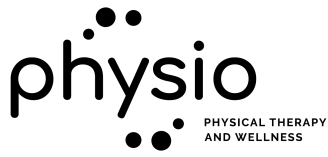
I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me

Patient Signature/Date

Patient's Representative Signature/Date

Witness Signature/Date

Relationship to Patient



Credit Card On File Agreement

If you would like to maintain a card on file with Physio, please complete the following:

- I, _____ authorize Physio Physical Therapy and Wellness to charge to my credit or debit card for the following reasons: Co-pays or co-insurance, cancel or no show fees, massages, laser, dry needling, and any other item and/or service that I give verbal or written permission for.
- I agree to be charged each visit period for the total amount due for that visit.
- I understand that I can request receipts at any time.
- I agree that no prior notification will be provided if the total payment is under \$150. If my bill is more than that amount, I will receive notice from us at least 1 day prior to the payment being collected.
- I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Cardholder Name: _____ Zip Code: _____

Account Number: _____ Expiration Date: _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX): _____

Full Name Date

Physio Representative Name Date

Signature

Signature

If you would like to opt-out of maintaining a card on file with Physio, please complete the following:

I, _____, would like to opt out. Please **DO NOT** keep my card on file.

Full Name Date

Physio Representative Name Date

Signature

Signature



What to Ask Your Insurance

Even though we are in-network with most major plans, there are many different types of insurance plans, and coverage varies.

Please note, that if you do not verify the following questions, you may receive an unexpected bill. By verifying your benefits ahead of time, you could save yourself from overpaying at the time of service.

Is Physio in-network? Yes No

Physio's National Provider Identifier (NPI) is 1588920342. (If your insurance is a CIGNA plan, please provide the tax ID 11-3670557 to ensure you are requesting your physical therapy benefits summary appropriately.)

What are the effective dates of my insurance? _____

Have I met my deductible? Yes No

If not, how much is left on my deductible? _____

Does my deductible apply to Physical Therapy? Yes No

What is my co-pay/co-insurance for Physical Therapy? _____

How many Physical Therapy visits are allowed per year? _____

Name of Representative you spoke with: _____

Call Reference Number: _____