

INTAKE FORM

Jate:		
Employee: _		
1, =		

		AND WELLNESS	Employee
Full Name:		Date of Birth:	Age:
Gender:	Preferred Pronouns:		
Address:			City/State/Zip:
Cell Phone:		Emails	
Home Phone		Anneigh	ment Reminders: • Text • Email • None
Emergency Contact:		Contact Phone:	
Referring Physician:		Primary Physician:	
How did you h	near about us? • Friend/Far	mily oInternet oFacebook	∘Advertisement ∘Other:
STRESS Level	l: low 1 2 3 4 5 high	What is the main cause?	
NUTRITION: V	What is your level of nutrition knowledge?	o none o a little o	o medium o a lot
ACTIVITY: Hov	w often are you active? Fred	quency:	Duration:
What is			
FITNESS Goal			increase flexibility & mobility
Other:	-	, ,	, ,
IMPODTANT D	RULES & POLICIES Please initial next to each.		
1	Late Policy: If you are more than 10 minutes late to yo	our appointment, you may be rescheduled	d or asked to wait for the next available time slot.
2	24-HOUR advance notice is required for changes to a	n appointment, otherwise a \$30 fee may ap	pply.
3	Co-pays and/or deductibles are due prior to treatmen	t.	
4	Not showing for an appointment without notice, will re	sult in a \$30 fee.	
5	Cell phones must be shut off or silent . If you need to t may result in cancellation of appointment.	ake a phone call, you may be asked to step	o outside for the duration. Phone calls during appointments
6.	Children must be supervised at all times unless they	are capable of remaining in the waiting are	a, without disruption, for the full appointment time.
7	We request that you verify your insurance benefits in a insurance coverage.		
8	If you are experiencing any financial hardship, please r	notifiv us immediately so we can do our bes	st to create a payment program that is feasible
9	If for any reason you are not satisfied with the care rec	,	1 7 1 3
equipment I may my participation total paralysis, de Physio, Inc., and a participation in th in part by the neg heirs, hereby volu claims, actions of these activities. I	in such activities and/or use of such equipment may reseath or other ailments that, could cause serious disability any other entity, person, or associate, the negligence of these activities and for use of equipment, I hereby assume gligence or the conduct of the representatives or employ untarily agree to release, waive, discharge, hold harmles r losses for bodily injury, property damage, wrongful dea	ers, and hazards and such exists in my use ult in injury or illness including, but not limi (c) these risks and dangers may be cause the participants, the negligence of others, a e all risks and dangers and all responsibility /ees of Physio, Inc., or by any other person. s, defend, and indemnify Physio, Inc. and the tith, loss of services or otherwise which may	of any equipment and my participation in these activities; (b) ted to bodily injury, disease, strains, fractures, partial and/or d by the negligence of the representatives or employees of
	E ABOVE WAIVER AND RELEASE AND BY SIGNING IT A FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRO		

Patient Name:	
Parent/Guardian Signature:	
Signature:	Date:



PRE-EXA

Date:	
Employee:	

Occupation:	ting now?	• Yes	- No
Please indicate the following on the body to the right using the designated symbols: /// Stabbing 000 Pins & Needles ZZZ Achy XXX Burning >>> Numbness Other: When did it start? When did it start? On the scale, circle your worst pain level in the last couple of days: **None 012345678910 Severe (Emergency Room)** How would you rate your ability to perform activities associated with your job? (If applicable.) **Unable to Perform 012345678910 No Problems** How would you rate your ability to perform routine daily activities? **Unable to Perform 012345678910 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 Over the next 30 days, how many hours per week will you commit to getting better? **MEDICAL HISTORY**			

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? **In No **In 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 Over the next 30 days, how many hours per week will you commit to getting better? **MEDICAL HISTORY**			
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 Problems 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 Over the next 30 days, how many hours per week will you commit to getting better? **MEDICAL HISTORY**			
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? **n No **n Yes			
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			
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 Over the next 30 days, how many hours per week will you commit to getting better? MEDICAL HISTORY			
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			
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			
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 Over the next 30 days, how many hours per week will you commit to getting better? MEDICAL HISTORY			
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 Over the next 30 days, how many hours per week will you commit to getting better? MEDICAL HISTORY			
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 Over the next 30 days, how many hours per week will you commit to getting better? MEDICAL HISTORY			
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 Over the next 30 days, how many hours per week will you commit to getting better? MEDICAL HISTORY			
How optimistic are you that you'll get better? Please circle one. Not at all Mildly Optimistic Fairly Over the next 30 days, how many hours per week will you commit to getting better? MEDICAL HISTORY			
MEDICAL HISTORY			
List all past surgeries with dates:			
List any medications you are taking:			
Check off any other conditions, allergies, chronic conditions, or precautions:			
■ Allergies ■ Cancer ■ Currently Pregnant ■ Gallbladder Problems ■ HIV/AIDS		•	■ Seizures
■ Anemia ■ Cardiac Conditions ■ Diabetes ■ Headaches ■ Incontinence ■ Application ■ Cardiac Pacemakor ■ Diagray Spells ■ Headaches ■ Headaches ■ Headaches			■ Smoking
■ Anxiety ■ Cardiac Pacemaker ■ Dizzy Spells ■ Hepatitis ■ Kidney Prol ■ Arthritis ■ Chemical Dependency ■ Emphysema/Bronchitis ■ High Cholesterol ■ Metal Impla	ce 🖪 Musc		Speech Problems
■ Autoimmune Disorder ■ Circulation Problems ■ Fibromyalgia ■ High/Low Blood Pressure ■ MRSA	ce Musc blems Oste	•	■ Strokes

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 rehabilitiation program and that my approval into their program is not guaranteed.

Patient/Guardian Signature



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:

- 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 feam
- 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

PHYSIO Physical Therapy & Wellness

Statement of Privacy Notice

Effective June 1, 2012

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

> You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

- > You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- > You have the right to inspect and copy your health information.
- > You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (828) 348-1780. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (828) 348-1780. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Physio, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)	
Patient's Signature	Date
Authorized Facility Signature	Date



Signature

Credit Card On File Agreement

If you would like to maintain a card on file with Physio, please complete the following: _____ 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. O 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. O 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 Physio Representative Name Date Date Signature Signature If you would like to opt-out of maintaining a card on file with Physio, please complete the following: _____, would like to opt out. Please **DO NOT** keep my card on file. Full Name Date Physio Representative Name Date

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 11-3670557to 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?
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: