**Patient Intake Form**

Completion of these forms is required in order to stay compliant with state/federal guidelines, meet insurance carrier requirements, and/or remain lawful with the state practice act. We are an independent healthcare provider and do not have access to your medical records, unless YOU request them to be sent to our office from your physician. Your patience and thoroughness while filling out these forms is greatly appreciated. Please ask receptionist for assistance with filling out these forms if needed; we are happy to help! We look forward to helping you recover, heal, and return to a high quality of life!

**Patient Information:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_/\_\_\_\_\_\_ SSN\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Cell Work Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male Female

Marital Status: Single Married Partnered Widowed Separated Divorced

Is the patient a minor? No Yes Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Cell Work Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:**

Same as referring physician

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accident Information:**

Is this injury due to an accident: No Yes

Place of injury: Home Work Community Auto Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Have you made a report of your accident? No Yes

Attorney name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Condition Form – Vertigo/Vestibular/Balance**

**Describe your condition**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did this condition begin?** (Date or Time) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My dizziness or imbalance symptoms are**: Constant Intermittent Unpredictable

**Symptoms are worst with:**  Rest Activity Walking In the morning In the evening

**Activities that provoke symptoms**: Sitting Standing Walking Bending Lying down

Stooping Rolling in bed Turing head quickly Driving

**Symptoms interfere with**: Work Sleep Daily Routine Recreational activities Self-care

Functional ability **BEFORE** onset of symptoms or injury: Excellent Good Fair Poor

Functional ability **AFTER** onset of symptoms or injury: Excellent Good Fair Poor

**Condition is getting**: Better Worse Not Changing Unpredictable

Have you taken **anti-dizziness/nausea medication** today? No Yes Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please rate your balance/ability to maintain your balance:**  Excellent Good Fair Poor

**How many times have you fallen in the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have pain?**  No Yes **Location of your pain:**

**Rate severity of pain on a scale of 0 – 10:** (Circle number)

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Call 911

**Type of pain**: Sharp Dull Throbbing Numbness Cramps Aching Tingling

Shooting Burning Stiffness Swelling Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family/Social History:**

**Living situation**: Alone With Family With Friend(s) Assisted Living Other: \_\_\_\_\_\_\_\_\_\_\_

**What type of home**: 1 story 2 story Apartment How many stairs? \_\_\_\_\_\_\_

**Job Status?** Full Time Part Time Light Duty On Leave Unemployed Retired

**Occupation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Duty Level**: Heavy Medium Light Desk

**Do you smoke?** No Occasionally Frequently: \_\_\_\_\_\_ packs per day.

**Do you drink alcohol?** No Occasionally Frequently: \_\_\_\_\_\_ drinks per day.

**Health History Form**

**Height:** \_\_\_’\_\_\_\_\_” **Weight:** \_\_\_\_\_\_\_ lbs. Are you currently receiving **Home Healthcare?** No Yes

**Treatment(s) already received for your condition/injury:**

Medication Surgery Physical Therapy Chiropractic Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of other doctors who have treated you for your condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you experiencing any of the following:** Changes in bowel/bladder Non-healing sores/wounds Fatigue

Unexplained weight loss Referred or radiating pain Fever/sweats

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Conditions:** | **Yes** | **No** |  | **Yes** | **No** |
| Osteoporosis |  |  | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Cancer Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Hearing or Visual Impairment |  |  |
| Diabetes: Type I Type II |  |  | Thyroid Problem |  |  |
| Arthritis: OA RA |  |  | Kidney Disease |  |  |
| High Blood Pressure |  |  | Vertigo |  |  |
| Circulatory Problems |  |  | History of Falls |  |  |
| Depression |  |  | Fibromyalgia |  |  |
| Seizures |  |  | Contagious Disease: \_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Heart Problems |  |  | Stroke Date:\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have a Pacemaker |  |  | Currently Pregnant |  |  |

**Diagnostic Testing Received**: X-ray MRI CT Scan **VNG** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have had testing, please provide dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other **injuries or diagnoses** not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all past **injuries and/or surgeries** you have had with dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **over-the-counter** medicationsor supplements you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **prescribed** **medications** that you are taking (or provide list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Release of Medical Records**

I hereby authorize Pure PT Physical Therapy to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

**PRIVACY NOTICE**

By my signature below, I acknowledge that I have received a copy of this practice’s Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

**TREATMENT COMMITMENT**

Pure PT Physical Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at Pure PT Physical Therapy:

1. Attending, on time, all scheduled appointments.

2. Informing your therapist of your progress, each visit.

3. Compliance with your treatment plan developed by your therapist.

4. Asking questions when you do not understand any instructions given to you by our staff.

5. Notifying your therapist in advance of your next doctor’s appointment.

**PATIENT MISSED APPOINTMENT POLICY**

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

**In an instance of cancellation, without 24 hours-notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show you will be charged a $50.00 fee. After the second no-show or third cancelled appointment, all future appointments will be removed from the schedule and you will be added to our “same day appointment only” list, which simply means that you will no longer be scheduled in advance, and you must now call us on days that you KNOW you can attend, and we will ATTEMPT to fit you in the schedule that day, however it won’t be guaranteed.**

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Legal Representative Date

**Financial Policy**

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients, this policy has been implemented for each patient. If you have medical insurance, we are happy to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

▪ Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and Discover. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances, we may accept assignment of insurance benefits.

▪ Deductibles, Co-insurance, and Co-payments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

▪ Please be further advised that Returned checks and balances older than 30 days from your Treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

▪ If you participate with our in-network groups such as MEDICARE, we will bill your insurance company and accept assignment of benefits. You will be responsible for any co-pays, co-insurances, or deductibles at each visit. We will verify your coverage and determine your out-of-pocket cost prior to treatment starting. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Please be aware of the following:

1. Your insurance is a contract between you, your employer and the insurance company.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.

3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.

4. We will not COMPRISE patient care based on an insurance companies “FEE SCHEDULE”.

5. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving Auto Claims and Worker’s Compensation, we will ONLY accept payment directly from the patient or from their insurance company and will arrange to accept payments from attorneys on a case-by-case basis. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill. We will accept settlements on auto accounts only after prior approval and a patient responsibility agreement form is on file. We must emphasize that as a Medical provider, our relationship is with you, not your insurance company.

While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, **PLEASE don’t hesitate to ask us. WE ARE HERE TO HELP YOU!**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Legal Representative Date

**Assignment of Medical Benefits, Payment**

**Responsibility, and Authorization for Treatment**

PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. THE UNDERSIGNED, hereby authorize Pure PT Physical Therapy and its affiliates (“Provider”) to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, “Therapy Services”) that Provider or Patientʼs treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Providerʼs rendition of Therapy Services.

2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.

3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patientʼs treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patientʼs Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.

5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.

6. THE UNDERSIGNED, authorizes Pure PT Physical Therapy to deposit checks received on Patientʼs account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.

7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Providerʼs invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider. THE UNDERSIGNED understands that they have a choice of rehabilitation service providers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature/Legal Representative Date