REV. 08.02.2019

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FOR OFFICE USE ONLY		
Day	Date	Time
DOC:		Acct #
Conf: Yes No		Staff #
Direct Access: Y ___ N ___		

PHYSICAL REHAB INTAKE FORM

Full Legal Name:_____/_____/_____
Last Name *First Name* *Middle Initial*

Age: _____ Date of Birth:_____/_____/_____ S.S. #:_____-_____-_____

Address:_____

City:_____State:_____Zip: _____

Telephone # (___)_____ Mobile: (__)_____

E-Mail address: _____

Gender: Female☐ (Pregnant?☐ /Plan to be Pregnant?☐) Male ☐

Single ☐ Married ☐ Other ☐ Partners Name: _____

Occupation:_____ ☐Full time ☐Part time ☐Student ☐Retired

Employer / School:_____Phone: _____

Address: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone# (_____)_____
Other than yourself, to whom may we disclose your Protected Health Information? _____

PCP AND CURRENT PHARMACY INFORMATION: (if no PCP, please put N/A in "Family MD" area)

Family MD _____ Phone # _____
Pharmacy _____ Phone # _____

What is the best way to communicate with you between office visits? (Select all that apply)
(Circling the form of communication desired is confirming consent)

☐E-mail ☐Home ☐Work ☐Cell Phone ☐Text

How were you referred to us? _____

How did you hear about us? ☐TV ☐Billboard ☐Radio ☐Internet ☐Other

Do we have consent to call you: ☐Yes ☐No On What Number? ☐Home ☐Mobile

What is the best time to reach you? ☐Morning ☐Afternoon ☐Evening

Is there any place you do NOT want me to leave a message?_____

**Please be aware that e-mails not a secure form of communication and that the discussion of our medical care will become a part of your medical record.*

PATIENT NAME:

HEALTH INSURANCE INFORMATION:

Do you have medical insurance? Yes ☐ No ☐
Do you have Medicare? Yes ☐ No ☐
Insurance Company Name _____
Insurance Company Phone_____
Type of Insurance: ☐ HMO ☐ PPO ☐ POS ☐ OTHER
Policy#_____ Group#_____
Policy Holders Name _____
Their DOB:_____ Relationship _____

Do have any other insurance? Yes ☐ No ☐
If Yes, complete below;
Insurance Company Name _____
Insurance Company Phone_____
Type of Insurance: ☐ HMO ☐ PPO ☐ POS ☐ OTHER
Policy#_____ Group#_____
Policy Holders Name _____
Their DOB:_____ Relationship _____

Referring Provider:_____Phone #:_____

Primary care provider:_____Phone #:_____

Have you ever been treated by a Physical Therapist? Y ☐ N ☐ Reason:_____

PROBLEM/CONDITION:

Diagnosis as stated by provider:_____

How did this injury/ exacerbation/problem occur?_____

Date it began:_____

Have you ever been treated by a PT for this present condition? Y ☐ N ☐

If yes: Where_____Date_____

Have you ever had surgery for this present condition? Y ☐ N ☐

If yes: Where_____Date_____

DIAGNOSTIC TESTING:

Have you ever had any of the following? EMG/NCV ☐ CT Scan ☐ MRI ☐ X-Ray ☐ Other ☐

Results: _____ When? _____Where?_____

FOR ATHLETES/SPORTS INJURIES ONLY:

What sport(s) do you play?_____

Were you injured during performance of sport? Y ☐ N ☐ If yes, what date did the injury occur?_____

Did injury occur at school or in a league? Y ☐ N ☐ Name of school/league: _____

AUTO ACCIDENTS/WORKERS COMPENSATION/PERSONAL INJURY ONLY:

Date of Injury:_____Where did injury occur: Work ☐ Auto ☐ Home ☐ Other ☐

If other, please explain:_____

PATIENT NAME:

Insurance Co Name:_____

Address:_____City_____State:_____Zip:_____

Claim #:_____Adjuster:_____Phone #:_____

Do you have an attorney? Y☐ N☐ Name:_____

Company:_____Phone #_____

Address:_____City_____State_____Zip_____

PHYSICAL REHAB INTAKE FORM: HEALTH INFORMATION:

HAVE YOU EVER BEEN TREATED FOR OR DIAGNOSED WITH THE FOLLOWING:

High Blood Pressure	Y____N____	Blood Disease	Y____N____
Heart Disease	Y____N____	Osteoporosis	Y____N____
Heart Attack	Y____N____	Circulation/Phlebitis	Y____N____
Breathing Problems	Y____N____	Cancer	Y____N____
Diabetes Mellitus	Y____N____	Stroke/TIA	Y____N____
Tuberculosis	Y____N____	HIV Positive/Aids	Y____N____
Lung Disease	Y____N____	Asthma	Y____N____
Disc Degeneration	Y____N____	Depression/Anxiety	Y____N____
Vascular Disease	Y____N____	Hepatitis/Liver Disease	Y____N____
Thyroid Problem	Y____N____	Kidney Disease	Y____N____

DO YOU HAVE A HISTORY OF/CURRENTLY HAVE ANY OF THE FOLLOWING:

Allergies	Y____ N____	Neuromuscular Problem	Y____ N____
Headaches/Migraine	Y____ N____	Arthritis	Y____ N____
Dizziness/Fainting	Y____ N____	Pain at Night	Y____ N____
Chest Pain/Angina	Y____ N____	Changes in Bowel/Bladder	Y____ N____
Seizures/Epilepsy	Y____ N____	Hot/Cold Intolerance	Y____ N____
Numbness/Tingling	Y____ N____	Unexplained Wt loss/gain	Y____ N____
Hearing Problems	Y____ N____	Broken Bone/Fracture	Y____ N____
Vision Problems	Y____ N____	Chronic Pain > 6 months	Y____ N____
Neck/Back Problems	Y____ N____		
Spinal Surgery	Y____ N____		
Joint Problems	Y____ N____		

PATIENT NAME:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have a pacemaker/defibrillator device? Y___N___

Do you smoke/Vape: Y___N___ ___packs per day ____times Vape/day

Do you consume alcohol? Y___N___If yes, type_____how often_____

Do you use street drugs? Y___N___If Yes, please discuss with provider.

Are you allergic to any medications? Y___N___Please list_____

Are you allergic or sensitive to Latex? Y___N___

Is your sleep disturbed? Y___N___Reason_____

Do you have a history of falls? Y___N___If yes, explain_____

Do you use an assistive device? Y___N___If yes, what type_____

Do you have any functional limitations? Y___N___

If yes, please explain:_____

What is your current activity level?____Sedentary____Light____Moderate____Heavy____Very Heavy

Do you regularly exercise? Y____N____Type_____Frequency_____Duration_____

Do you have any home activities/Hobbies? Y___N___

If yes, please list_____

MEDICATIONS AND SUPPLEMENTS:

What medications (prescribed or over the counter) are you currently taking? Including Vitamins?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY SURGERIES AND APPROXIMATE DATES:

_____ _____

_____ _____

PATIENT NAME:

RATE YOUR CHIEF COMPLAINT IN ORDER OF SEVERITY FROM WORST (10) TO LEAST (1):

Please check all that apply:

Pain ☐ Decreased Motion ☐ Swelling/Edema ☐ Stiffness ☐ Loss of Function ☐

INDICATE THE NATURE OF YOUR PAIN/SYMPTOMS. CHECK ALL THAT APPLY:

Sharp ☐ Dull ☐ Piercing ☐ Shooting ☐ Aching ☐ Deep ☐ Superficial ☐

Tingling ☐ Numbness ☐ Burning ☐ Stabbing ☐

What makes your symptoms worse?_____

What makes your symptoms/pain lessen?_____

Rate your symptom/pain on scale (0-10): no pain=0, excruciating pain =10

Worst it has been_____ Past 2 weeks_____ Past 24hrs_____ At this moment____

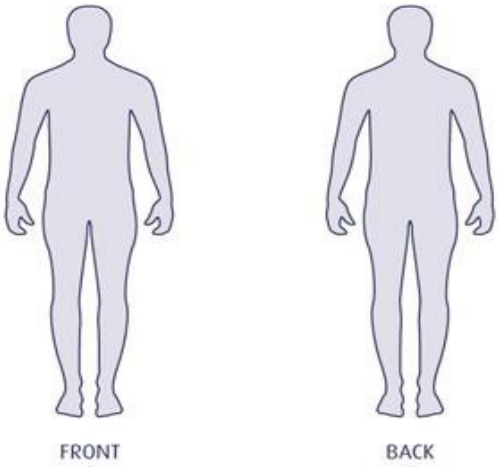
PLEASE MARK LOCATION OF YOUR PAIN AND TYPE OF PAIN ON THE CHART:

X: Sharp stabbing

O: Dull/achy

///: Numb/Tingling

++: Burning



Please list 3 of your goals for Physical Therapy and expected time frame:

1._____

2._____

3._____

Whom can we thank for your referral?_____

PATIENT NAME:

CONSENT FOR TREATMENT:

The signature below authorizes consent to have your picture taken for the sole purpose of Identification.
This material will not be sold or distributed for any reason.

The information I have provided is complete and true to the best of my knowledge. I authorize the providers and staff of Allegheny Medical, P.C. to administer such procedures and treatments as deemed necessary, or as required by my employer. There is no written, verbal, or implied guaranteed cure on our part. Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment of services

PATIENT SIGNATURE:_____DATE:_____

REVIEWED BY:

PHYSICAL THERAPY SIGNATURE:_____DATE:_____

Thank you for Your Patience and Valuable Time

PATIENT'S PHYSICAL THERAPY PLAN OF CARE:

_____x/Week for _____Weeks

ASSIGNMENT OF BENEFITS:

I_____authorize Allegheny Medical, P.C. to be paid directly for services rendered. I accept responsibility for any service(s) that may not be covered by my health insurance, automobile insurance, or workers compensation carrier. I further authorize Allegheny Medical, P.C. to furnish information concerning my present illness or injury which may contact alcohol, drug, HIV or psychiatric related history to the insurer and health care providers involved in my care. I further direct the insurer to pay without equivocation directly to Allegheny Medical, P.C. any and all benefits due as a result of treatment and service(s) provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier.
I hereby state and agree that a photocopy of this document will be deemed as valid and bindings on all parties involved as the original copy.

PATIENT SIGNATURE:_____ DATE:_____

GUARDIAN SIGNATURE:_____ DATE:_____

PATIENT NAME:

MEDICARE ASSIGNMENT OF BENEFITS:

In accordance with the Medicare Act, Section 1842 (I) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (II) (A) of the Medicare act. If Medicare determines that a particular service(s), although normally covered is not reasonable and necessary because the service(s) is maintenance in nature as defined by Medicare policy, Medicare will deny payment for those service(s). In your case, Medicare is likely to deny payment for the service(s) for lack of medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. that in my case, Medicare is likely to deny payment for those service(s).

If Medicare denies payment, I agree to be personally and fully responsible for payment.

PATIENT SIGNATURE:_____ DATE: _____

GUARGIAN SIGNATURE:_____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

□ I acknowledge that I have received and read "Notice of Privacy Practices" from Allegheny Medical, P.C.

_____	_____	_____
DATE	PRINT NAME OF PATIENT	SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

□ I decline to read or accept a copy of the "Notice of Privacy Practices" from Allegheny Medical, P.C.

_____	_____	_____
DATE	PRINT NAME OF PATIENT	SIGNATURE OF PATIENT/PERSONAL RESPRESENTATIVE

PATIENT NAME:

Physical Therapy: Missed Appointment and Cancellation Policy

Our goal is to provide quality individualized care in a timely manner to each of our patients. No-shows, late arrivals, and cancellations inconvenience those individuals who need access to our care. We would like to review with you our policy regarding missed appointments.

CANCELLATION OF AN APPOINTMENT/ MISSED APPOINTMENT (No shows)

Appointments are in high demand. If you need to reschedule an appointment for any reason we require a 24 hour notice. This policy enables us to better utilize available appointments for patients in need of Physical Therapy. A cancellation is considered late when the appointment is cancelled without a 24 hour advanced notice.

MISSED APPOINTMENTS (NO SHOWS)

We will charge a $50 missed appointment fee if we do not receive a 24 hour notice of cancellation.

If a second appointment is missed we will charge the cost of services that would have been incurred at the time of the appointment.

If a third appointment is missed within a year, and no appointment is rescheduled, the patient will be dismissed from the practice.

LATE ARRIVALS

Patients arriving 15 minutes or later for an appointment will be asked to reschedule the appointment for another day. If possible, an attempt will be made to reschedule the same day in the next open appointment slot. This appointment may be brief in nature due to the need to work you in between other scheduled patients.

I have read and understand the Missed Appointment, No Show, Late Arrival, and Cancellation Policy of Allegheny Medical and I agree to its terms.

_____ Date:_____

Patient Signature

_____ Date:_____

AM Staff Signature (witness)