THE PHYSIOFIX PATIENT INTAKE FORM

Please complete all pages of this form and then either email it to office@thephysiofix.com, fax to (949) 553-3561, or bring it in to us at your first session. If you have any questions, please call us at (602) 734-5610. Thank you!

PATIENT INFORMATION

Patient Email Address:			Today's Date:			
Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one): Single / Married / Divorced / Separated / Widowed	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name(s):	Birth date: / /	Age:	Sex: ❑ M	❑ F
Street Address:		Social Security #:	Cell Phone #: ( )			
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer Phone #: ( )				
Referred to or chose our clinic because (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Web search	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

Please give your insurance card to the front desk staff.

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone #: ( )		
Is this person a patient here?	❑ Yes ❑ No				
Occupation:	Employer:	Employer address:	Employer Phone #: ( )		
Is this patient covered by insurance?	❑ Yes ❑ No				
Primary insurance name/plan					
Subscriber's Name:	Subscriber's SSN.:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child	❑ Other:		
Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:		
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Physio Fix or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ *Date* _____

THE PHYSIOFIX HEALTH HISTORY QUESTIONNAIRE

Please fill out this form in its entirety to assist your physical therapist in developing the best plan of care for you. If you have any questions, don't hesitate to ask for assistance. The information collected here will remain confidential unless authorized for release by the patient.

Patient Name: _____ Date of Birth: _____/_____/_____

Occupation: _____ Hobbies: _____

Date of Injury (if applicable): _____/_____/_____ Gender: _____

Circle whether your injury was SUDDEN ONSET or GRADUAL ONSET

Has this injury prevented you from working? Circle one: YES NO

If yes, how long have you been out of work? _____

Regarding your work status, at the **PRESENT TIME** I can:

_____Work without restrictions
_____Work the same job with restrictions
_____Work a different job with restrictions
_____Unable to work due to dysfunction
_____Don't normally work outside the home
_____Homemaker
_____Retired
_____Other

Is there a case for the injury that involves an attorney? Circle one: YES NO

If yes, please provide the ATTORNEY NAME: _____ PHONE #: _____

Have you sought previous treatment for this condition?

_____No other treatment
_____Physical/Occupational Therapy
_____Chiropractor
_____ Massage Therapy
_____Psychiatrist/Psychologist
_____Other: _____

List any prescription medications you are taking, including injections and skin patches:

_____

_____

List any over-the-counter medications you are taking, including vitamins and supplements:

_____

_____

List any surgeries or other conditions for which you have been hospitalized:

Date of Surgery/Hospitalization	**Type of Surgery/Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please check any of the following symptoms that you are currently having or have experienced in the past 3 months:

_____Fever
_____Chills
_____Skin Rash
_____Pins/Needles
_____Numbness
_____Night Sweats
_____Vision Problems
_____Hearing Loss
_____Shortness of Breath
_____Headaches
_____Bowel/Bladder Problem

THE PHYSIO FIX

Please check any of the following conditions that apply to you either currently or in the past:

_____High Blood Pressure	_____Chest Pain/Heart Attack	_____Stroke	_____Gout
_____Heart Disease	_____Cardiovascular Disease	_____Allergies	_____Asthma
_____Epilepsy/Seizures	_____Kidney Disease	_____Hepatitis	_____Arthritis
_____Tuberculosis	_____Varicose Veins	_____Depression	
_____Lung Disease	_____Hearing Loss	_____Thyroid Problems	
_____Dizziness/Fainting	_____Emphysema/Bronchitis	_____Emotional/Psychological Problems	

_____Chemical Dependency (alcohol/drugs)

_____Other: _____

Are you aware of your current diagnosis? Circle one: YES NO

Do you have questions regarding your diagnosis or prognosis? Circle one: YES NO

Note any other comments or concerns you have: _____

_____

PAIN LEVEL ASSESSMENT: Scale: **0/zero = no pain** and **10/ten = the worst pain you have ever experienced**

My current pain level is a _____.

Throughout the day, my pain ranges from a _____ to a _____.

Describe the location of your pain (body part, front/back/side, etc.):

_____

Describe the type of pain (dull, sharp, stabbing, achy, tender, tight, etc.):

_____

My pain gets better when I: _____

My pain gets worse when I: _____

ADDITIONAL QUESTIONS:

Have you ever been treated at The Physio Fix? Circle one: YES NO

If yes, when? _____ Patient Name: _____

Have you had physical therapy, occupational therapy, or chiropractic treatment this year? Circle one: YES NO

If yes, please indicate the type of treatment and the duration of treatment? _____

_____

Have you previously had physical therapy for this condition? Circle one: YES NO

If yes, for how long? _____

<u>For Medicare Patients Only</u>:

Are you currently receiving home care services? Circle one: YES NO

If yes, when will you be completely done with home care? _____

Do you have a home care discharge letter? Circle one: YES NO

<u>For Student-Athletes Only</u>:

What sport(s) does the student-athlete play? _____

Was the student athlete injured during the performance of the sport? Circle one: YES NO

If yes, what date was the student athlete hurt? _____

Was the student athlete hurt at school or in a league? Circle one: SCHOOL LEAGUE NOT APPLICABLE

If yes, was any paperwork filed with the school or league? Circle one: YES NO

Name of School or League: _____

THE PHYSIO FIX

Newsletter:

To provide our patients with great customer service and the latest information regarding our services, you may periodically receive emails from our company and its affiliates. If you prefer NOT to get these emails, please check this box:

□ Opt out of Newsletter

Patient or Guardian Agreement:

□ I acknowledge that The Physio Fix may disclose protected health information for the purposes of payment, treatment, and healthcare operations.

□ I understand that I am responsible for any balance due and owing The Physio Fix for services rendered.

All Patients:

□ CONSENT TO TREATMENT: I consent to receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician. However, I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

In conjunction with my care, I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to The Physio Fix and/or the treating physician through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that The Physio Fix will not further use or disclose such film or images for any other purpose without my authorization or consent. **Check one:** □ Yes □ No

Financial Responsibility:

I agree to pay The Physio Fix all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third-party insurance plan, a third-party payor, or other payor source on my behalf for services rendered. In the event this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

THE PHYSIO FIX

AUTHORIZATION & CONSENT TO TREAT A MINOR

Date: ___ /___ /____

Minor Name: _____ Minor Date of Birth: ___ /___ /____

The undersigned does hereby provide *The Physio Fix* staff with consent to examine and treat the above-mentioned minor <u>without</u> a Parent or Guardian present.

Father or Guardian Signature: _____

Mother or Guardian Signature: _____

Witness Signature: _____

Important Medical Information (Allergies, Medications, etc.):

_____
_____
_____
_____

THE PHYSIO FIX

PATIENT NOTIFICATION POLICY

Patient Name: _____

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, ***The Physio Fix*** will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment, and health care operations. Furthermore, The ***Physio Fix*** will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, The ***Physio Fix*** will only disclose your appointment information, such as reminders or cancellations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise. This notice refers to The Physio Fix as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

I, the undersigned, hereby authorize ***The Physio Fix*** to disclose my appointment information by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable:

Answering Machine: ( ) _____ - _____

Voice Mail: ( ) _____ - _____

Text Message: ( ) _____ - _____

E-Mail: _____

Patient/Guardian Signature: _____ *Date:* _____

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. You further agree to be responsible for notifying ***The Physio Fix*** if any of this information changes.

I, the undersigned, hereby authorize ***The Physio Fix*** to disclose my PHI to the person(s) named below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient/Guardian Signature: _____ *Date:* _____

THE PHYSIOFIX

FINANCIAL POLICY

Thank you for choosing The Physio Fix! Please *carefully* review our Financial Policy. It is important for you to have a thorough understanding of your physical therapy benefits and financial responsibilities. This Policy Agreement must be initialed, signed, and submitted by the initial appointment.

NO INSURANCE / CASH RATE

The Physio Fix offers self-pay cash rates and packages for anyone – whether you don't have health insurance, don't want to use insurance, have reached your maximum insurance benefits, and/or have insurance that we do not accept.

*Acceptance Initials*_____

MEDICAL INSURANCE COVERAGE

The Physio Fix accepts Blue Cross Blue Shield health insurance plans (*other health insurance may be accepted on a case-by-case basis solely at the discretion of The Physio Fix*). Prior to your initial visit we will gather the information needed to verify your current insurance coverage and benefits.

If you have not provided us with your insurance information prior to your first appointment, we have no way of verifying your benefits and you will be asked to pay the self-pay cash initial evaluation rate at the time of service. Once your benefits have been verified, the money you paid for the initial visit will convert to a credit on your account that can then be applied to your co-pay or deductible.

NOTE: Verification of physical therapy benefits is NOT a guarantee of payment.

It is ultimately your responsibility to know your physical therapy benefits and all coverage is based on insurance coverage at the time of service.

*Acceptance Initials*_____

CO-PAYMENTS AND DEDUCTIBLES

As part of our contractual agreement with your insurance company we must collect these fees directly from you. Often your annual deductible must be met before insurance will pay for physical therapy benefits. Co-payments will be collected at each visit. Please present your copayment upon arrival.

*Acceptance Initials*_____

UNPAID BALANCES

Account balances over 60 days without a payment or payment agreement will be subject to assignment to an out-of-office collection assistance agency. Should this be necessary, a transfer fee of $25 will be added to your account.

I understand that I am responsible for any balance due and owing The Physio Fix for services rendered. I agree to allow The Physio Fix to charge the credit card on file in my account for all remaining balances after 30 days from the last date of service unless otherwise notified.

*Acceptance Initials*_____

I have read, understand, and agree to the terms stated above. I realize I am financially responsible for payment of my account with The Physio Fix regardless of my insurance coverage.

Signature of Patient: _____ *Date Signed:* ___ /___ /_____

Printed Patient Name: _____

Parent/Guardian Signature: _____ *Date Signed:* ___ /___ /_____
(if patient is a minor)

THE PHYSIOFIX

APPOINTMENT POLICY

Thank you for choosing The Physio Fix! Please *carefully* review our Appointment Policies.
This Policy Agreement must be initialed, signed, and submitted by the initial appointment.

CANCELLATIONS

If you need to cancel an appointment, please call us ASAP **(24 hours' notice)** so we can offer your appointment to another patient. If less than 24 hours' notice is given to our office, you will be charged a **$50** cancellation fee.

*Acceptance Initials*_____

NO SHOWS

If you do not show up for a scheduled appointment, you will be charged a **$50** no-show fee.

*Acceptance Initials*_____

LATE ARRIVALS

All appointments are 1-on-1 with a Doctor of Physical Therapy. If you are late for an appointment, you have the option to use the remaining length of your appointment time, or you can choose to reschedule for another day/time and be charged a **$50** fee.

*Acceptance Initials*_____

I have read, understand, and agree to the terms stated above. I realize that I am financially responsible for any charges incurred from cancellations, late arrivals, and no shows.

Signature of Patient: _____ *Date Signed:* ___ /___ /_____

Printed Patient Name: _____

Parent/Guardian Signature: _____ *Date Signed:* ___ /___ /_____
(if patient is a minor)