36397 N Gantzel Rd Suite 102
San Tan Valley, AZ 85140
P: 480-567-2987 F: 480-347-0240

Date:_____________________

NEW PATIENT INTAKE

Legal Name (Last, First, Middle):____
Preferred Name:______________________________Date of Birth: _______________Age: __________
SS #: _________________________Address: ____
City: ____ State: _______ Zip: ______________
Home Phone:________________ Cell: ________________Email: ____
Referring Physician: ____Phone: _______________________
When is your next doctor follow up visit: ____
Emergency Contact: ________________________________Phone:_________________Relationship:________________

As a courtesy we verify your benefits. We strongly encourage you to do so.

PRIMARY INSURANCE

Policy Holder: ____________________________ DOB_________ Patient relationship to policy holder_____________
Insurance Company: __________________________________ ID#________________Group#___________________
Policy Holder Employer:____

SECONDARY INSURANCE

Policy Holder: ____________________________ DOB_________ Patient relationship to policy holder_____________
Insurance Company: __________________________________ ID#________________Group#___________________
Policy Holder Employer:____

WORKERS COMPENSATION

Employer Name:_________________________________ Contact Person:_______________Phone:_______________
Date of Injury: ______________ Claim#________________________

ADDITIONAL INFORMATION

Have you been seen by a Physical/Occupational Therapist this calendar year? __________________________________
Have you recently had home health therapy? ____
How did you learn about Inbalance PT? ____
What is your goal for therapy?____

PLEASE INITIAL EACH SECTION

_______Cancellation/Late Policy

If it becomes necessary for you to cancel or reschedule an appointment, please notify the office 24 hours in advance, when possible. We realize extenuating circumstances i.e. emergencies may occur. However, exceptions to this rule are made at the discretion of management. If repetitive cancellations and/or no shows occur, you may be charged a cancellation fee of $25.00 per occurrence. The cancellation fee will be the responsibility of the patient, as most insurance companies will not compensate our practice for canceled appointments or no-shows. We appreciate your patronage and ask your cooperation in maintaining the Cancellation and No Show Policy. Thank you.

_______Consent To Treat

I consent to rehabilitation and related services at Inbalance Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. In cases of minor children, I, as a parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any

claim I may have resulting from failure to do so.

_______Financial/Insurance Policy
I hereby assign all insurance benefits to Inbalance Physical Therapy for services performed as a result of my illness or injury. Non-insured Patient: I agree that I am responsible for payment at the time of service, unless prior arrangements have been made. Deductible / Coinsurance: I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible is met, my coinsurance amount will be collected at time of service. Non-covered Procedure: I agree to pay for all non-covered services (preventative or routine) not paid by my insurance. Collections: After having a balance on your account for 90 days and have not set up a payment plan with our billing department or paid in full you will be sent to a collections agency. Once an account is placed in collection status all future services must be paid in full at the time of service. I understand that there will also be a $25 returned check fee.

_______Notice Of Privacy Practices
I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used,disclosed, protected, and how I can get access to this information is available to me upon request.

_______Release Of Medical Records
To complete my insurance claim and treatment, I authorize Inbalance Physical Therapy to release my medical records to my physician(s), clinic, hospital, Workers Compensation or insurance company (including government programs).

_______Referral And Insurance
I understand that in the check in process, if I do not have my referral and/or insurance card I will be responsible for any payment rendered at the time of service. I understand that I am responsible to know if my insurance company requires preauthorization for my treatment. I also understand that I can avoid this expense by bringing my referral and/or insurance card to my scheduled check in time or I understand that I can call my referring Doctor's office and have these items faxed to Inbalance Physical Therapy prior to my scheduled appointment.

_______Treatment Precaution
It is possible that during the course of treatment here at Inbalance Physical Therapy, exacerbation (flare-ups) of conditions (known or unknown) may occur. Every attempt will be made to minimize such an occurrence and should one occur, appropriate action will be taken by the therapist.

_______Additional Items
Cell Phones: We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.
Children: Children requiring supervision are not allowed to attend sessions with you.
Guests: Due to space and to respect other patient's privacy, we ask that guests please wait in the reception area.

By signing below I acknowledge that I have read, understand and agree to all of the above. I understand that if I have questions regarding the above policies that it is my responsibility to ask.

*Patient/Parent/Guardian/Signature:*____*Date:*________________

MEDICATION PROFILE

Patient Name:_________________________________ Date of Birth:______________ Today's Date:________________
Allergies or Precautions:
____
____

If you have a current list of your medications, please bring it and we will make a copy in lieu of this form.

Name of Medication	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (mouth, injection, etc)
Example: Lasix	*20mg*	*High Blood Pressure*	*2 x a day*	*mouth*

MEDICAL HISTORY

Patient Name:_________________________________ Date of Birth:____________ Today's Date:_____________

Brief summary of why we are seeing you:____
____
____
Have you had any imaging and do you have the results?____

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain: At best ____________ At worst____________ Today____________

CONDITION	YES	NO	CONDITION	YES	NO
Angina			Peripheral Vascular disease		
Anxiety or Panic Disorders			Stroke or TIA		
Arthritis (RA, OA)			Visual Impairment		
Asthma			Headaches		
Chronic Obstructive Pulmonary Disease			Bleeding Disorders		
Congestive Heart Failure (CHF)			Cancer		
Degenerative Disc Disease			Dizzy or Fainting Spells		
Depression			Epilepsy or Seizure Disorder		
Emphysema			High Blood Pressure		
Hearing Impairment			Hypoglycemia		
Heart Attack			Hepatitis A, B, C		
Multiple Sclerosis			Kidney Problems		
Osteoporosis			Liver / Gallbladder Problems		
Parkinson's Disease			Nausea / Vomiting		
Pregnancy			Dizziness/lightheadedness		
Smoking			Tuberculosis		
Pacemaker			Diabetes Type I or II		
Falls or balance problems			Shortness of breath		

Other not listed:____
____
____
____

MEDICAL INFORMATION RELEASE
(HIPAA RELEASE)

Patient Name: ____ Date of Birth:_____________________

From time to time we may need to contact you or we may have inquiries about you from people/groups other than your physician(s), clinic, hospital, Workers Compensation or insurance company (including government programs).
To protect your privacy please fill out the following information.

RELEASE OF INFORMATION

_____I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

_____Spouse:____
_____Child(ren):____
_____Parent:____
_____Other:____

_____Information is not to be released to anyone (except as specified under the NEW PATIENT INTAKE).

MESSAGES
Please call: Home #______________________ Work #______________________ Cell #______________________

If unable to reach me:

_____ You may leave a detailed message.
_____ Please leave a message asking me to return your call.
_____ Other ____

Best times and days to reach me:____

The RELEASE OF INFORMATION and MESSAGES will remain in effect until terminated by me in writing.

Signature:____ Date:_____________________________

Witness:____ Date:_____________________________