NEW PATIENT INTAKE Date:_____

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#_____

Initial _____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 copays. 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.

Initial _____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.

ADDITIONAL INFORMATION

Have you been seen by a Physical/Occupational Therapist this calendar year? _____

Have you recently had home health therapy? _____

PLEASE INITIAL EACH SECTION

Initial _____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.

Initial _____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).

Initial _____Cancellation/Late Policy

Please provide us with 24-hour notice to change or cancel an appointment. We recognize emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, 24-hour notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. For Monday appointments, the expectation is to contact us on the Friday prior. Patients who No-Show a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $40.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. After two No Shows or late cancellations, you may be placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

Initial _____Consent To Treat

I consent to rehabilitation and related services at Inbalance Physical Therapy. In doing so, 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.

Initial _____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.

Initial _____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, guests please wait in the reception area.
Pets: No pets allowed. Only service animals, for example: a dog that has been individually trained to do work or perform tasks for an individual with a disability.

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?_____

PAIN: On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain: At best _____/10 At worst_____/10 Today_____/10

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:_____