MALETTA PFEIFFER & ASSOCIATES

PATIENT INTAKE FORM

Name: _____ **S.S.N.** _____

Preferred Name: _____ **Sex:** _____

Date of Birth: _____ **Gender Identity: (pronouns)** _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____ ⬜ **Text Reminder**

Email: _____ ⬜ **Email Reminder**

Emergency Contact: _____ **Phone Number:** _____

Relationship to Patient: _____

Referring MD: _____

Primary Care MD: _____

Primary Insurance: _____

Policy Number: _____

Is Patient Guarantor: **YES / NO**

If no,

Guarantor's Name: _____

Guarantor's Date of Birth: _____

Secondary Insurance: _____

Policy Number: _____

Signature: _____ **Date:** _____

OFFICE POLICY

Payment for the Initial Evaluation is expected at the time of the evaluation unless there are prior arrangements. We will bill all primary insurance directly, however, payment for services rendered is always the responsibility of the patient. Each patient not having insurance, or for which the insurance plan will not provide payment in full, is required to pay at the time of service. By insurance regulation, a patient is responsible to pay all the deductible and coinsurance due. Therefore, any deductible that has not been met as well as the coinsurance (normally 20% of billed charge) is due at the time of each visit. Any other amounts not paid by insurers but due us will be collected at the time of service.

As a convenience to you we are more than happy to bill your insurance carrier. However, if payment is not received in a reasonable period of time, it is the responsibility of the patient to follow through with insurance companies regarding delay in payment(s).

We accept referrals from other practitioners besides medical doctors. However, insurance companies have refused to pay claims that have not been referred by a medical doctor. Therefore, you are responsible for services rendered upon receipt of service.

Cancellation of Appointments: 24-hour advance notice is required. Please understand staff and space are allocated for your visit. If you do not show these costs are incurred by us. There will be a $30.00 charge for late cancellations or missed appointments. This is not reimbursable by insurance companies and is the responsibility of the patient to pay at the time of his/her next visit.

Collections: Should your account default after 90 days, it will be turned over to our collection agency.

Motor Vehicle or Other Liability Accidents: Please provide this office all no-fault, liability or other accident information, requested on the registration form, so we can properly bill your insurance. If no-fault benefits are exhausted and your health insurance carrier will not approve continued treatment, you are responsible for payment at the time of service.

Worker's Compensation: In order for us to process these claims we will need a letter from your insurance company accepting responsibility for payment. If responsibility for payment is not received, the patient is responsible for payment at the time of service. Many times Worker's Compensation carriers approve a limited number of visits and without notice will reject further treatment. Anytime this may happen the patient is responsible for payment at the time of their next visit.

Medicare: We have contracted with Medicare, which means that we have agreed to accept Medicare payment for approved charges. This does not relinquish the patient's responsibility for payment, at the time of service, for the deductible or any treatments not approved by Medicare. Please provide us with the name and ID # for any MediGap insurance under secondary carrier on the registration form.

[ ] Photo ID Presented. **[ ] Insurance Card(s) Presented.**

Information below provided by office staff:

Copay per visit: _____

Deductible Plan – YES / NO / MET **If YES or MET,** cost per visit: _____

Visits allowed on plan: _____

I have been informed of my co-pay/coinsurance responsibility and I understand the above information and agree to the terms stated above.

_____ Date _____

(Signature of insured and responsible party)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practices from Maletta Pfeiffer & Associates.

Signature:_____ Date: _____

[ ] accepted copy [ ] refused copy

Reviewed by: _____

Medical History Form

Name:_____**Today's Date:**_____
Date of Birth:_____ **Height:**_____**Weight:**_____

Chief Complaint

Why are you seeing the PT today? _____

Current problem is in result of: [ ] Car Accident [ ] Work Accident [ ] Other (explain)

_____

Have you ever been treated for this condition before? [ ] NO [ ] YES – by whom? _____ when? _____

Please list any other serious illnesses, injuries, significant surgeries or hospitalizations and why? _____

_____

_____

_____

Are you allergic to any foods or medications? [ ] YES [ ] NO If yes explain: _____

Are you allergic to latex? [ ] YES [ ] NO

Do you smoke? [ ] YES [ ] NO Do you use drugs or alcohol? [ ] YES [ ] NO

Do you wear glasses? [ ] YES [ ] NO Do you wear a hearing aid? [ ] YES [ ] NO

At this present time, would you say that your health is [ ] Excellent [ ] Very good [ ] Fair [ ] Poor

REVIEW OF SYMPTOMS

Are you currently having or have you had any problems with:

	Circle One		**Describe all YES responses**
Asthma	No	Yes	_____
Arthritis	No	Yes	_____
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Pacemaker	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackouts/Fainting	No	Yes	_____
Psychological Problems	No	Yes	_____
AIDS/HIV	No	Yes	_____
Cancer	No	Yes	_____
Epilepsy/Seizures	No	Yes	_____
Heart Disease	No	Yes	_____
Kidney Disease	No	Yes	_____
Pregnancy	No	Yes	_____
Osteoporosis/Osteopenia	No	Yes	_____
Stroke	No	Yes	_____

Would you like to learn more about natural nutritional supplements? [ ] No [ ]Yes

Would you like one of our therapists to talk to you about our weight management program? [ ] No [ ]Yes

Patient Signature:_____ Date:_____

Reviewed By: _____ Date:_____

MEDICATION LIST

Please list all medications below:	Dosage
PRESCRIPTION:	
VITAMINS/HERBAL SUPPLEMENTS:	
OVER-THE-COUNTER MEDICATIONS:	
TAKEN AS NEEDED (PRESCRIPTION OR OVER-THE-COUNTER)	

Print Name:_____

Signature:_____ **Date:** _____