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NEW PATIENT INTAKE FORMS

Date:_____

Patient Name:_____DOB:_____ ☐ M ☐ F
First MI Last

Mailing Address:_____City,State,Zip:_____

Cell Phone:_____ Work/Home Phone:_____

Occupation:_____Email:_____

Check where applicable: ☐ Computer Work? Hrs/Day:_____ ☐ Prolonged Driving? Hrs/Day:_____
☐ Heavy Lifting? Lbs/how often:_____ ☐ Pushing/Pulling? Explain: _____

If Minor, Guardian Name:_____DOB:_____Relationship:_____

Marital Status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ MINOR ☐ WIDOWED OTHER:_____

Emergency Contact

Name:_____Relationship:_____Phone:_____

Were you referred to Tri-PT by: ☐ Surgeon ☐ Rehab ☐ Physician ☐ Patient:_____
Other:_____

Family/Primary Care Physician:_____Phone:_____

Address:_____City,State,Zip:_____Fax:_____

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PATIENT LAST NAME, FIRST INITIAL:_____

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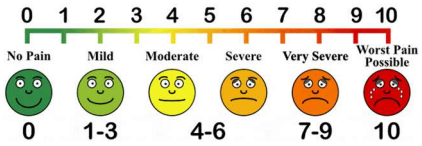
PATIENT MEDICAL HISTORY

On a scale from 0-10 Please list your pain: ⟶



Pain Scale: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications: ☐ Yes ☐ No **(Please List Below)**

Anti-Inflammatories _____
Muscle Relaxers _____
Pain Medication _____
Other _____

Have you had any of the following diagnostic, medical, or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	_____	_____	General Practitioner	_____	_____
EMG	_____	_____	CT Scan	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Physical Therapy	_____	_____	X-Rays	_____	_____
Emergency Room Care	_____	_____	Orthopedist	_____	_____
Neurologist	_____	_____			

Do you now or have you ever had any of the following?

***Place X where applicable below*:**

	CHECK				
Asthma, Bronchitis, or Emphysema	☐	High Blood Pressure	☐	Anemia	☐
Shortness of Breath/Chest Pain	☐	Heart Attack or Surgery	☐	Diabetes	☐
Coronary Heart Disease or Angina	☐	Thyroid Trouble/Goiter	☐	Gout	☐
Cancer/Chemotherapy/Radiation	☐	Dizziness or Fainting	☐	Weakness	☐
Emotional/Psychological Problems	☐	Infectious Diseases	☐	Hernia	☐
Bowel or Bladder Problems	☐	Numbness or Tingling	☐	Allergies	☐
Severe or Frequent Headaches	☐	Elbow/Hand Injury	☐	Osteoporosis	☐
Vision or Hearing Difficulties	☐	Neck Injury/Surgery	☐	Stroke/TIA	☐
Sleeping Problems/Difficulties	☐	Back Injury/Surgery	☐	Blood Clot/Emboli	☐
Leg/Ankle/Foot Injury/Surgery	☐	Knee Injury/Surgery	☐	Epilepsy/Seizures	☐
Do you have a Pacemaker?	☐	Arthritis/Swollen Joints	☐	Varicose Veins	☐
Any Pins or Metal Implants?	☐	Are you pregnant? Y ☐ ____ Weeks:		Joint replacement	☐
Weight Loss/Energy Loss	☐	Do you smoke? Y ☐ N ☐			

**** Please list any additional information that would assist us in providing you care?**

_____

_____

_____

Are you Left handed or Right handed? ☐ L ☐ R

Are you aware of your diagnosis (what you are being treated for at our clinic)? ☐ Yes ☐ No
Based upon your awareness of your diagnosis, what are your expectations/goals while being treated in our office?

_____

Office use only:

PATIENT LAST NAME, FIRST INITIAL:_____ PAGE ☐ OF ☐

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Informed Consent for Physical Therapy Services

Physical Therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Tri-Physical Therapy, Inc does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

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 Tri-Physical Therapy 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 Tri-Physical Therapy will not further use or disclose such film or images for any other purpose without my authorization or consent.

☐ **Yes** ☐ **No**

In addition, we may occasionally take pictures/video for our social media pages (i.e. Facebook and Instagram), would you be willing to allow Tri-Physical Therapy to utilize approved pictures/video of you with your consent?

☐ **Yes** ☐ **No**

I have read the Informed Consent for Physical Therapy Services section in it's entirety and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Printed Name:_____ **Date:**_____

Signature:_____**Date:**_____

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PATIENT LAST NAME, FIRST INITIAL:_____

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Patient Financial Responsibility:

Tri-Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. *However, you are ultimately responsible for the payment of your bill.*

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at our office or mailed to the address on your statement.

I have read the above policy regarding my financial responsibility to Tri-Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Tri- Physical Therapy. I agree to pay Tri-Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____(relationship to patient: if not self:_____)
Printed Name:_____Date: _____

Please note that the information included in this Statement of Financial Responsibility form is subject to any applicable state laws, rules or regulations that impact your financial responsibility and whether there is an amount owed.

24 Hour No Show/Cancellation Policy:

At Tri-Physical Therapy, we value the time you commit to us in order to achieve your healthcare goals. We hope you value our time as well. We pride ourselves in offering our patients one-on-one treatments to ensure the highest quality of care. While this level of integrity is not common in most medical facilities, we believe that it is what each patient deserves when they are being treated in our office. This means that each time you come in, one of our team members has reserved that specific time to work with you. In order to maintain this level of care, it is imperative that any patient that needs to reschedule or cancel their appointments do so in a timely manner.

This time frame is 24 Hours from the time of your appointment

In order to ensure that we can continue to deliver the same caliber of care to our patients, we will be enforcing a cancellation fee for all appointments cancelled or rescheduled within 24 hours of the schedule time of the appointment.

Cancellation fee will be $40.00 (per scheduled appointment for that day) and will be charged at the time of your next appointment via cash, debit, or credit card (swipe only). We appreciate your understanding of this policy and valuing our time as much as we value yours.

I _____(name) Acknowledge the Tri-Physical Therapy cancellation policy. I understand that I will be charged the indicated fee if I cancel or reschedule an appointment within 24 hours of my appointment.

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PATIENT LAST NAME, FIRST INITIAL:_____

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Health Insurance Carrier Consent & Agreement

On your behalf, we are pleased to file your care to your insurance company. Please be aware, however that since we are out of network and often out of state, the check for these services will be issued to you and in your name. By signing below, you are agreeing that you understand that payment will be issued to you and that you will be required to forward the check(s) to you as a payment for services rendered.

If bringing insurance checks is difficult for you, we have a couple of options for you:

1) We can safely keep a credit card on file if you choose to deposit those checks received. We will run the card on file as payment for the full amount issued on the check.

2) We can provide you with a stamped, self-addressed envelope to forward all checks to us. Please open all correspondence from your insurance carrier, as it often is difficult to recognize that checks are enclosed. Please forward payment to us immediately. If you have any questions, feel free to contact us at: (602) 956-1233.

3) Please be aware that if you have signed up (with your insurance carrier) to receive electronic *EOB's, your checks issued may not include a copy enclosed when payment is sent/addressed to you. If this is the case, it will be your responsibility to forward the EOB pertaining to the date of service issued on the check. FYI: The date of service and the date the check was issued are entirely different. The quality of your care and services within our facility are essential! If you have any questions, feel free to contact our billing service line at: 508.422.0233 Ext. 500

Thank You,

Tri-Physical Therapy
Billing Department

_____ _____

Patient Signature **Date**

_____

Patient's Printed Name

An **explanation of benefits (commonly referred to as an **EOB** form) is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB is not a bill. It simply explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid and any balance you're responsible for paying the provider. It also tells you how much has been credited toward any required deductible.*

Office use only:

PATIENT LAST NAME, FIRST INITIAL:_____

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Patient Notification Policy

(**Notice of Privacy Practices: HIPAA**)

Patient Name: _____

Date: _____

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, Tri-Physical Therapy 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, Tri-Physical Therapy will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Tri-Physical Therapy 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 Tri-Physical Therapy as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

I, the undersigned, hereby authorize Tri-Physical Therapy 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. I further agree to be responsible for notifying Tri-Physical Therapy if any of the foregoing change.

I, the undersigned, hereby authorize Tri-Physical Therapy to disclose my PHI to the person(s) named below.

_____

Name Relationship Phone #

_____

Name Relationship Phone #

Patient/Guardian Signature: _____Date: _____

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PATIENT LAST NAME, FIRST INITIAL:_____

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By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures that Tri-Physical Therapy has in place for it's facility, practices, and it's staff.

Those policies and procedures include:

☐ **Informed Consent for Physical Therapy Services**

☐ **Patient Financial Responsibility**

☐ **Fee Schedule**

☐ **24 Hour No/Show Cancelation Policy**

☐ **Health Insurance Carrier Consent & Agreement**

☐ **HIPAA/Patient Notification Policy**

Printed Name:_____ **Date:**_____

Signature:_____**Date:**_____

Office use only:

PATIENT LAST NAME, FIRST INITIAL:_____