Julie Glenn, MS, PT Integrative Physical Therapy - (401)580-3662- jglennpt72@gmail.com - julieglennpt.com

Patient Intake Form

Patient Information:

Last Name: _____ First Name: _____ Sex: _____

Date of Birth: _____Address_____

City: _____ State: _____ Zip Code: _____

Work#: ( ) _____ Home#: ( ) _____

Email: _____ Mobile#: ( ) _____

Employer's Name: _____

Occupation: _____

Referring or Primary Physician's Name: _____

Diagnosis: _____ Injury: Work or Auto related? _____

Emergency Contact: _____ Phone#: ( ) _____

Patient Questionnaire/ History

What is your Chief Complaint?

_____

_____

Rate your chief complaint in order of severity from worst (5) to least (1)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____ Loss of function_____

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

_____

When and how did this problem begin?_____

_____

What makes your symptoms/ pain worse or better?

_____

Rate your pain on a visual rating scale (0-10) ; 0 (no pain) 10 (excruciating pain)

Best _____ Worst _____

Past 2 to 4 weeks_____ Past 24 hours_____ At this moment_____

Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent_____

Are your symptoms: Improving_____Worsening_____Stable_____

Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways.

_____

_____

Have you had past similar episodes of this current problem? If yes, were you treated with; (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. , Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other, Did they help to alleviate your symptoms?

_____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?_____

Please answer the following questions: Yes No

1) Do the current problems interrupt your sleep?
2) Do your symptoms change with coughing or sneezing?
3) Have you had any recent changes in bowel or bladder function?
4) Do you experience any dizziness or vertigo?
5) Have you had any recent change in your weight or appetite?
6) Do you have any intolerance to hot or cold?
7) Do you have any bruising or bleeding disorders?
8) Have you had any skin changes, such as rashes or discoloration?
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?
10) Have you had a recent episode of nausea/vomiting?
11) Are you pregnant?
12) Do you have osteoporosis? Date of your last bone scan:
13) Do you have any allergies (seasonal or medication)?
14) Have you noticed any shortness of breath or decrease in exercise tolerance?
15) Do you use any assistive devise? (cane foot orthotics)
16) Do you have high blood pressure?
17) Do you have any cardiac problems?
18) Do you have diabetes?
19) Have you ever had cancer of any sort?
20) Do you have a history of neck or back problems?
21) Any metal implants, pacemaker or replaced joints?

Any other illness, past injuries I should be aware of?

_____

Past surgeries___yes, ___no, give brief details:

_____

List the medications you are currently taking (over the counter/prescription):

_____

_____

Social History
Are you presently working?

_____

Physical/Emotional demands of present occupation? (High, moderate, minimal)_____

_____

Overall activity level: _____Sedentary, _____Light, _____Moderate, _____Heavy, _____Very heavy.

Sports and Exercise (Type, Frequency, Duration)

_____

_____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No

THC/Medical or Recreational Marajuana Yes _____ No_____, CBD Yes ____ No _____

Family medical History:

Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?

_____

_____

Please list 3 goals of Physical Therapy and time frames:

1)_____

2)_____

3)_____

Who can we thank for this referral? _____

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

___ I do not consent to any voicemail, email or texting communication.

- I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)

___ Email

___ Text

___Voicemail

- I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)

___Email

___Text

___Voicemail

E-mail address: _____

Phone number: _____

Patient Signature _____Date_____

Parent/Guardian Signature _____Date_____

Payment Agreement

Thank you for choosing Julie Glenn, MS, PT Integrative Physical Therapy as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

Payment is expected at time of service unless you have made other payment arrangements with us.

Out-of-Network Policy. (Commercial Health Plans) We are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

Prevention, Wellness & Fitness Services. Most commercial health plans and Medicare do not cover the prevention, wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.

I have read, understand and agree to these payment terms. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Julie Glenn, MS, PT Integrative Physical Therapy. and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Julie Glenn, MS, PT Integrative Physical Therapy and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X _____ Date: _____

Signature of Patient and/or Guardian

A photocopy of this agreement is to be considered valid, the same as if it was the original.

Cancellation Policy

_____ (Initial) I understand Julie Glenn, MS, PT Integrative Physical Therapy requires 24-hour advanced notice for appointment cancellations or rescheduling. When I schedule a one-hour in office or in-home physical therapy appointment with Julie Glenn, MS, PT Integrative Physical Therapy that time is reserved for me. When you do not provide a minimum of 24-hour notice of cancellation, this does not give your physical therapist the opportunity to offer your time to another patient in need of treatment. If I cancel an "in office" or “in home” appointment less than 24 hours or no show to an "in office" appointment, I agree to allow Julie Glenn, MS, PT Integrative Physical Therapy to charge me. The cancellation fee is equal to the normal cost of the “in office” or “in home” treatment.

Credit Card Payments
I hereby authorize Julie Glenn, MS, PT Integrative Physical Therapy, to charge my credit card, debit card or HSA/FHA card only for the agreed amount for services rendered. By signing below, I agree to allow Julie Glenn, MS, PT Physical Therapy to charge my credit card for the services rendered. I understand that this information is to be kept private and secure by Julie Glenn, MS, PT Integrative Physical Therapy.

Credit Card Type: VISA/MC/AMEX Zip Code: _____ CSV Code_____ Account Number: _____ Exp Date: _____ Cardholder Name:_____ Authorized Card Holder Signature_____

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICE

Patient: _____

I, _____ hereby acknowledge that I have received a copy of The

Notice of Privacy Practices.

Signature: _____

Relationship to Patient (if patient is a minor):_____

Date: _____

Consent to Treatment

I consent to have Julie Glenn, MS, PT Integrative Physical Therapy to provide physical therapy services at Julie Glenn, MS, PT Integrative Physical Therapy Office, in my home, office or via Telehealth. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read this consent form, understand the benefits and risks involved in physical therapy, and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care.

Patient's Name (Printed) _____ Patient's Signature _____Date_____
Parent/Guardian Signature _____Date_____