PATIENT INTAKE FORM

Name: ____ ***Date of Birth:*** ___/___/______

Nickname: _________________________________ ***Social Security #:*** _______-_______-______

Local Address: ____

City: ________________________________ ***State:*** _________________ ***Zip Code:*** ___________

*(Please check preferred method of contact)

- ☐ ***Home Phone:*** ________-_______-________
- ☐ ***Cell Phone:*** ________-_______-________ (Does cell phone have Text Ability: Yes / No)
- ☐ ***Email Address****: ____

***(Used for mailing purposes and Home Exercise Programs)**

Occupation: ____

Place of Employment: ____

Primary Insurance: Name: _____________________________ ***Policy #:*** ________________________

Secondary Insurance: Name: _____________________________ ***Policy #:*** ________________________

Tertiary Insurance: Name: _____________________________ ***Policy #:*** ________________________

Is This Work Related or Due to Auto Accident? Yes / No If Yes, Claim#: ___________________

Adjuster or Case Manager Name: ____________________ ***Date of Injury:*** ____/____/________

Emergency Contact:

Name____________________________ ***Number***_____________________

If Applicable: Out of State Address: ____

City: _____________________________ ***State:*** _________ ***Zip Code:*** ________________

PATIENT/GUARDIAN SIGNATURE: ________________________________ **DATE:** ____________

CONFIDENTIAL MEDICAL HISTORY FORM

NAME: ______________________________ ***Injury or Reason for Visit:***______________________________________

When did Symptoms begin? _____________ ***(approx.) Diagnostic Testing Done?*** (x-rays, MRI, etc) _________________

Have you received Physical Therapy for this in past? Yes / No ***Any Physical Therapy This Year?*** Yes / No

Surgery? Yes / No ***Date of Surgery?*** ____/_____/______

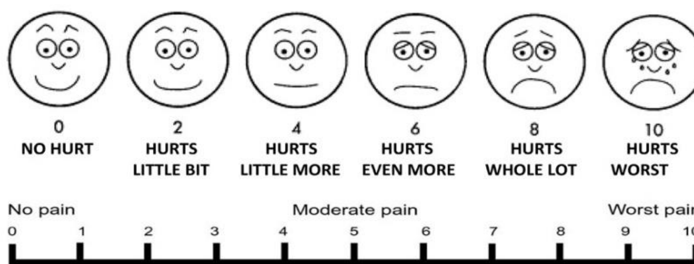
Hospitalization? Yes / No ***Date of Hospitalization?*** From: ___/___/____ To: ___/___/____

Are you having Pain? Yes / No (0-10)

If so, what is it Currently? _________

At worst? _________

At its Best? __________



Are you receiving any Home Health Care? Yes / No ***Date of Discharge:*** _____/_____/______

FALLS: ***Have you fallen?*** Yes / No If Yes, ***Date of Last Fall***: _____/_____/_______

Surgical History: ____

Medication List: or *(See Attached):____

*(When was list of medication(s) last revised by Primary Care Physician?) Date: ______/_____/_______

Do you Smoke? Yes / No ***Alcohol Consumption?*** _______/week ***Are you Pregnant?*** Yes / No

***Please check medical conditions you currently have or had in the past**

	Asthma, Bronchitis, Emphysema		Arthritis, Swollen Joints		Shortness of Breath, Chest Pain
	Varicose Veins		Osteoporosis		Pace Maker
	High Blood Pressure		Severe/Frequent Headaches		Cancer or Chemo/Radiation
	Sleeping Difficulties		Thyroid Trouble/Goiter		Diabetes
	Heart Attack, Surgery		Vision/Hearing Difficulties		Gout
	Emotional, Psychological Problems		Anemia		Coronary Heart Disease
	Stroke/TIA Bowel or Bladder Problems		Dizziness or Faintness		
	Epilepsy/Seizures		Infectious Disease		

PATIENT/GUARDIAN SIGNATURE: _______________________________ **DATE:** _____________

PAYMENT POLICY & CONSENT TO TREAT PAYMENT POLICY:

Our staff will verify your insurance as a courtesy and will notify you the information they receive. Insurances always state it is not a guarantee of payment. As the patient, it is your responsibility to be familiar with your particular insurance policy and its obligations. This includes your obligations to see a participating provider, know your coverage and its limitations, and be prepared to pay any out-of-pocket expenses at the time of your visit. Please refer to our website www.proptfl.com for further explanation. Health care regulations require us to collect all copayments, coinsurances, deductibles and balances for noncovered service fees. Failure on our part to collect from the patient their financial responsibility can be construed as fraud. If for some reason you find it necessary to cancel a visit, please call us within 24 hours of your appointment to reschedule, as there is a time on the schedule reserved specifically for you. Cancellations are sometimes unavoidable, however, in order to enforce this policy you will be charged $40 if you cancel less than 24 hours prior or you do not show up to your scheduled appointment. We are obligated to report all no-show and cancellations to your doctor and the involved insurance companies. Worker's compensation patients must take extra precautions in attending physical therapy as treatment can be disrupted for non-compliance.

ACKNOWLEDGEMENT I have read the above, and understand my responsibilities regarding my insurance coverage and payment policy. I understand that I am responsible for any charges that are not covered by my insurance carrier. I understand that I am responsible to notify the office of any changes in insurance that may occur. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

SIGNATURE: ____ **DATE:** ______________

CONSENT TO TREAT:

I, ________________________, hereby agree and give my consent to receive medical treatment for my physical condition. I authorize release of any medical information needed to process my claim. **I authorize release of payment to LEGENDARY PHYSICAL THERAPY, LLC.** regardless of participation in or out of network. I acknowledge that I have received, read and understand the NOTICE OF PRIVACY PRACTICES.

SIGNATURE: ____ **DATE:** ______________