DASH
Physical Therapy

PATIENT INTAKE FORM

PERSONAL INFORMATION

Patient Full Legal Name :

Patient Preferred Name :

Date Of Birth : _____/_____/_____ **Gender** : _____

Address : _____

Phone Number : _____ **E-Mail** : _____

Insurance ID Number : _____ **Social Security Number** : _____

Insurance Group Number : _____ **Worker's Comp Claim #** : _____

Cardholder's Name : _____ **Relation to Cardholder** : _____

Referred By : ☐ Insurance ☐ Hospital ☐ Doctor _____ ☐ Other _____

Occupation : _____ **Is the Injury Due to Accident?** : ☐ Yes ☐ No

Accident Details : _____

_____

_____

_____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Mobile Number** : _____

Relationship : _____ **Alternate Number** : _____

**I Authorize the release of any medical or other information necessary to process insurance claims.*

Patient/ Guardian Signature : _____ ***Date*** : _____

OFFICE USE ONLY

Date : _____ **Injury Type** : _____

Patient Chart Number : _____ **Payment Type** : _____

Staff Name : _____ **Staff Signature** : _____

More Information :

18530 E. San Tan Blvd Suite 109 Queen Creek, AZ 85142

(480) 677-8202 (Office) (480) 677-8203 (Fax)

https://dashphysicaltherapy.net/

dashphysicaltherapy@gmail.com

THANK YOU

DASH Physical Therapy

POLICY AGREEMENT FORM

CANCELLATION & NO SHOW POLICY

Due to limited availability of appointments, we have a $25.00 No Show/Cancellation Fee. Canceling an appointment with less than 24 hours notice will result in a charge to the payment on file. This is the patient's responsibility and not able to be billed to your insurance.

By Signing this, I Confirm that I Understand and Agree to this Policy. ☐ **YES** ☐ **NO**

Patient/ Guardian Signature : _____ **Date :** _____

Patient/ Guardian Printed Name : _____

MEDICAL RELEASE AGREEMENT - HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct treatment and follow-up among the healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the right to review Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested, but if you do then you are bound to follow such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have take action relaying on this consent.

Patient Name : _____ **Date :** _____

Patient/Guardian Signature : _____ **Relation to Patient :** _____

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POLICY AGREEMENT FORM

FINANCIAL POLICY & CONSENT FOR CARE

Thank you for choosing DASH Physical Therapy. We are committed to providing successful treatment to our patients. Please understand that the patient's bill is considered a part of the treatment. The following is a statement we require patients to read and sign before any treatment.

Regarding Insurance

DASH Clinic will bill insurance companies for treatment visits. The copays given at the time of service is the price given to us from the patient's insurance company/ or our self payment rate. It is the patient's responsibility to make these payments in full in a timely manner. If the patient has questions about the premium, deductible, or copays, it is best to contact the insurance company directly for those answers. Most insurance cards have a customer support number listed on the back of your card. Since every plan is different, we cannot provide reasoning for copays to every patient.

Participating Provider Insurance Plans & Customary Rates

All copayments and deductibles are due when services are provided. Please arrange payment before the appointment begins. Our practice is committed to providing our patients with the best possible treatments, requiring us to charge a usual and customary rate for our area. Please be aware that some services may be non-covered services. This means that they are not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Consent for Care & Treatment

I, the undersigned, do hereby agree and give my consent for DASH Physical Therapy to provide medical care and treatment considered necessary and proper in diagnosing or treating the diagnosed physical and mental condition.

Benefit Assignment/Release of Information

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to DASH. A photocopy of this assignment is to be considered as valid and original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

By Signing this, I Confirm that I Understand and Agree to this Policy. ☐ **YES** ☐ **NO**

Patient/ Guardian Signature : _____ **Date** : _____

Patient/ Guardian Printed Name : _____

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MEDICAL HISTORY FORM

Patient Full Legal Name :

Patient Preferred Name :

Date Of Birth : _____/_____/_____ **Gender :** _____

PATIENT HISTORY OF PRESENT INJURY

Please Have the Patient Answer the Following Questions:

1) Have you received a therapy assessment or treatment within the current year? ☐ **YES** ☐ **NO**

2) Are you currently under Home Health Care or Hospice? ☐ **YES** ☐ **NO**

3) Have you had surgery for this injury within the last eight (8) weeks? ☐ **YES** ☐ **NO**

4) Have you had a cast removed from the injured body part within the last two (2) weeks? ☐ **YES** ☐ **NO**

5) Is this injury the result of a workplace accident? ☐ **YES** ☐ **NO**

6) Is this injury the result of a mor vehicle accident that has occurred within the last 90 days? ☐ **YES** ☐ **NO**

To Rule out Contraindications to Treatment, Mark an "X" in the Appropriate Box if You have ever Suffered from Any of the Following Health Problems:

☐ Seizures/Stroke ☐ Bleeding Problems ☐ Seizures/Stroke ☐ Diabetes ☐ Osteoperosis

☐ Blood Clots ☐ Blood Pressure ☐ Chest Pain ☐ Cancer ☐ Anemia ☐ HIV

Mark with an "X" Which of these Symptoms Below you Currently Suffer From:

☐ Shortness of Breath ☐ Nausea/Vomiting ☐ Dizziness ☐ Fever/ Chills/ Sweats

☐ Difficulty Swallowing ☐ Changes in Bowel & Bladder Functions ☐ Numbness/Tingling ☐ Increased Pain at Night

History of Present Injury

What part of your body is currently injured? _____

What medications are you currently taking? _____

Are you taking pain medications? If so, please list: _____

Are you taking anti-inflammatories? If so, please list: _____

When and how were you injured? _____

Acknowledgement: I have completed this form to the best of my knowledge and ability.

Patient Name : _____ **Date :** _____

Patient/Guardian Signature : _____ **Relation to Patient :** _____