PURSUIT™
PHYSICAL THERAPY

Patient Intake Form

Patients Name: _____ DOB: _____

Parent/Guardian (if minor): _____ Gender: ☐ MALE ☐ FEMALE

Address: _____ Home Phone: _____

City, State: _____ Cell Phone: _____

Zip Code: _____ Work Phone: _____

Email: _____ Employer: _____

SSN: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Insurance Info

Is this a work related injury? ☐ YES ☐ NO

Is this a Motor Vehicle Accident? ☐ YES ☐ NO

Primary Insurance

Provider: _____ Name of Insured: _____

Relationship to Patient: _____ Guarantees DOB: _____

Policy Number: _____ Group Number: _____

Secondary Insurance

Provider: _____ Name of Insured: _____

Relationship to Patient: _____ Guarantees DOB: _____

Policy Number: _____ Group Number: _____

Referral Info

Referring/Primary Physician: _____

If referred, whom may we thank? _____

How did you hear about us?

☐ Friend/Family ☐ Social Media

☐ Internet/Website ☐ Physician/Doctor

Other: _____

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Medical History Form

Patient Name: _____ DOB: _____

Social History

Do you currently smoke/use tobacco? No ☐ Yes ☐ Packs/Day: _____

Have you smoked in the past? No ☐ Yes ☐ How many years did you smoke: _____

Do you drink alcohol? No ☐ Yes ☐ Drinks/wk: _____

Medical Conditions: (Check all that apply)					
☐	Alzheimer's	☐	Fibromyalgia	☐	MI/Heart Attack
☐	Anxiety	☐	Heart Problems	☐	Osteoarthritis
☐	Asthma	☐	Hernia	☐	Osteoporosis
☐	Blood Clotting Disorder	☐	High Cholesterol	☐	Parkinson's
☐	Bowel Incontinence	☐	HIV/AIDS	☐	Rheumatoid Arthritis
☐	History of Cancer	☐	Hepatitis	☐	Scoliosis
☐	CVA (Stroke)	☐	Hypertension	☐	Seizure Disorder
☐	DJD	☐	Lung Disease	☐	Thyroid Problems
☐	Depression	☐	Lymphedema	☐	Tuberculosis
☐	Diabetes (1 or 2)	☐	Mental Disorder	☐	Urinary Incontinence
☐	Dizziness/Fainting	☐	Migraine Headaches	☐	Other:
☐	DVT	☐	Multiple Sclerosis	☐	Other:
Do you have a pacemaker? YES ☐ NO ☐					
Are you currently pregnant? YES ☐ NO ☐					
Have you experienced falls in the past year? YES ☐ NO ☐					

Do you have any allergies (ex. medication, food, latex)? _____

List ALL Surgeries: _____

_____

_____

_____

List ALL Medications: _____

_____

_____

_____

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Pain/Injury Questionnaire

Patient Name: _____ DOB: _____

Describe how this started: _____

_____

How long have you had your current symptoms: _____

List 2-3 specific activities that are difficult to do because of your current condition:

1. _____
2. _____
3. _____

Do you feel your symptoms are: ☐ Improving ☐ Worsening ☐ Not changing

What specifically makes your pain worse? _____

What helps reduce your pain? _____

Rate your pain between 0-10: (0 = no pain, 10 = worst pain imaginable

_____ CURRENT (your pain today)

_____ WORST (last 24 hours)

_____ BEST (last 24 hours)

Have you had similar problems before? ☐ No ☐ Yes

Number of previous episodes: ☐ 1-5 ☐ 6-10 ☐ 11+

What treatments have you tried? _____

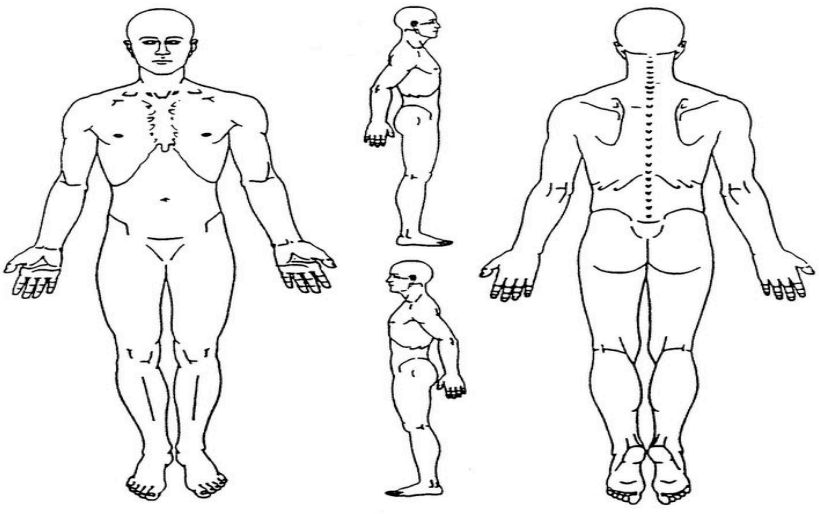
Does your condition interrupt your sleep? ☐ Yes ☐ No

Have you had: ☐ X-rays ☐ MRI ☐ CT scan ☐ Injection Other test: _____

List 2 realistic goals you would like to accomplish while in physical therapy (please be specific)

1. _____
2. _____

Please draw your symptoms:



= Pain

= Spasm/Tightness

= Numbness/Tingling

Consent For Treatment

I, the undersigned, hereby consent to receive medical or healthcare services from Pursuit Physical Therapy (hereafter referred to as "Provider") for the purpose of diagnosis, treatment, and/or management of my health condition(s).

Acknowledgment of Information

- I understand that the purpose of treatment, including risks and potential benefits, will be explained to me by the Provider.
- I will have the opportunity to ask questions regarding my diagnosis, treatment options, and the proposed plan of care, and my questions will be answered to my satisfaction.
- I understand that there are inherent risks associated with medical treatment, including but not limited to: possible complications, side effects, or failure to achieve desired outcomes.

Consent to Treatment

- I hereby consent to any diagnostic procedures, treatment, medication, or other healthcare services deemed necessary by the Provider.
- I understand that my consent is voluntary and may be withdrawn at any time, provided I notify the Provider in writing.

Privacy and Confidentiality

- I understand that my personal health information will be protected in accordance with applicable laws and the Provider's privacy policies.
- I authorize the Provider to disclose necessary medical information to other healthcare professionals, insurance companies, or as required by law for the purpose of treatment, payment, and healthcare operations.

Payment and Insurance

- I agree to provide accurate information regarding my insurance coverage and understand that I am financially responsible for any co-pays, deductibles, or non-covered services.
- I understand that if my insurance coverage changes, I must notify the Provider as soon as possible.

Termination of Care

- I understand that the Provider may discontinue care if I do not follow the prescribed treatment plan or if the Provider determines that continuing care is no longer appropriate.

Acknowledgment

I have read and understood this Consent to Treat Agreement. By signing below, I voluntarily agree to the terms outlined above. I confirm that the information provided is accurate and complete to the best of my knowledge. I consent to the use of this information for my treatment and care.

Print Name: _____ Date: _____

Signature of Patient: _____

Signature of Parent/ Legal Guardian: _____ Relation to Patient: _____

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Cancellation Policy

To ensure fair scheduling and timely availability of appointments for all patients, Pursuit Physical Therapy has established the following cancellation policy:

- **24-Hour Notice Requirement**
  - We require at least 24 hours' notice for all appointment cancellations or rescheduling.
  - Cancellations made less than 24 hours prior to the scheduled appointment will incur a $50 cancellation fee.

- **Missed Appointments**
  - If you fail to show up for a scheduled appointment without prior notice, a $50 no-show fee will be charged to your account.
  - The fee is non-refundable and must be paid before you can reschedule any future appointments.

- **Rescheduling Appointments**
  - If you need to reschedule, please contact us at least 24 hours in advance.
  - Failure to do so will result in the same $50 cancellation fee.

- **Exceptions**
  - Emergencies or unforeseen circumstances will be reviewed on a case-by-case basis, but the $50 fee may still apply unless waived by the provider.

By signing this agreement, you acknowledge and agree to abide by this Cancellation Policy.

Print Name: _____ Date: _____

Signature of Patient: _____

Signature of Parent/ Legal Guardian: _____ Relation to Patient: _____

Notice of Privacy Practices

Effective Date: May 5, 2026

We are committed to protecting your personal health information (PHI) and ensuring that it is used and disclosed appropriately. This Notice of Privacy Practices explains how we may use and disclose your health information, your rights regarding your health information, and our legal obligations concerning your health information under the Health Insurance Portability and Accountability Act (HIPAA).

Uses and Disclosures of Your Health Information

We use your health information for various purposes, including but not limited to:

- Treatment: Providing care and coordinating with other providers.
- Payment: Submitting claims to insurance companies and collecting payment for services rendered.
- Healthcare Operations: Activities like quality assessments, staff training, and compliance monitoring.
- With Your Authorization: We will not use or disclose your health information for marketing purposes or disclose highly confidential information (e.g., HIV status, mental health information) without your written authorization.

Your Rights Regarding Your Health Information

You have the right to:

- Access and Copy Your Information: Request access to your health records and receive a copy.
- Request Restrictions: Ask us to limit how your information is used or disclosed.
- Request Amendments: Request corrections to your health information if you believe it is inaccurate or incomplete.
- Receive Confidential Communications: Request communications via a preferred method or location.
- Receive a Copy of This Notice: Request a paper copy of this notice at any time.
- File a Complaint: If you believe your privacy rights have been violated, you can file a complaint with us or with the U.S. Department of Health and Human Services (HHS).

Our Responsibilities

We are required to:

- Maintain the privacy of your PHI and provide you with this notice.
- Abide by the terms of this notice.
- Notify you of any breaches of your PHI.
- Notify you if we make significant changes to this notice.

Complaints

- If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Contact Information

- If you have questions about this notice, your rights, or how to file a complaint, please contact us at:

Pursuit Physical Therapy
2056 S. Eagle Rd
Meridian, ID 83642
(208) 906-8469
admin@ptpursuit.com

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand this Notice of Privacy Practices. I understand that Pursuit Physical Therapy will use and disclose my health information for the purposes described in this notice.

Print Name: _____ Date: _____

Signature of Patient: _____

Signature of Parent/ Legal Guardian: _____ Relation to Patient: _____

Medicare Billing Policy

Medicare Eligibility and Coverage

- We verify Medicare eligibility for all patients prior to providing services.
- Medicare typically covers medically necessary services provided to eligible patients.
- It is the patient's responsibility to ensure they are enrolled in Medicare and to provide accurate Medicare information.

Assignment of Benefits

- By signing our consent form, patients authorize Pursuit Physical Therapy to bill Medicare on their behalf for covered services.
- Medicare payments are sent directly to Pursuit Physical Therapy, and any remaining balance is the responsibility of the patient.

Medicare Claims Submission

- We will submit claims to Medicare for services rendered that are deemed medically necessary and covered under Medicare guidelines.
- Claims will be submitted in a timely manner, based on Medicare billing regulations.

Patient Responsibilities

- Patients are responsible for any applicable co-pays, deductibles, or non-covered services.
- It is the patient's responsibility to ensure that Medicare is the correct primary payer for the services provided.
- Patients must provide accurate and up-to-date Medicare information.

Non-Covered Services

- Medicare does not cover certain services (e.g., elective procedures, cosmetic services, or services deemed not medically necessary).
- Patients are responsible for paying for these non-covered services.

Authorization and Consent to Release Information

- By signing this policy, patients authorize Pursuit Physical Therapy to release medical information to Medicare, as required to process claims.
- Patients also authorize Medicare to release information to Pursuit Physical Therapy regarding payment and coverage.

Appeals and Denials

- If Medicare denies a claim, we will notify you of the denial and the reason for it.
- Patients may request an appeal of denied claims. We will provide necessary assistance in navigating the appeals process, but the final responsibility lies with the patient.

Privacy and Security of Medicare Information

- We are committed to protecting your Medicare information and ensuring it is used only for legitimate purposes as required by law.
- Your Medicare information will be handled in compliance with HIPAA regulations.

Acknowledgment and Signature

I have read and understood this Medicare Billing Policy. By signing below, I agree to the terms outlined above and authorize Pursuit Physical Therapy to bill Medicare on my behalf.

Print Name: _____ Date: _____

Signature of Patient: _____

Signature of Parent/ Legal Guardian: _____ Relation to Patient: _____