Patient Intake Form

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Date of Birth _____ Age_____ Sex _____ Social Security Number_____-_____-_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____ Work Phone_____

Email Address _____ Appointment Reminders Text ☐ Call ☐ Email ☐

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

RESPONSIBLE PARTY- Patient is responsible party ☐

Name _____ Relationship _____ Date of Birth_____

Address _____ City _____ State _____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

INSURANCE INFORMATION- Personal Insur.☐ Medicare☐ Medicaid☐ Work Comp☐ Auto☐ Self Pay☐ VA☐

Primary Insurance Provider: _____ Member ID_____

Group Number _____ Policy Holder Name _____ Date of Birth _____

Secondary Insurance Provider: _____ Member ID _____

Group Number _____ Policy Holder Name _____ Date of Birth _____

PHYSICIAN

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Have you had any other therapy in the past year? Physical Therapy☐ Occupational Therapy☐ Speech Therapy☐
Have you been treated with a Chiropractor in the past year? Yes☐ No☐
Is this current concern/complaint the result of an accident? Yes☐ No☐ Accident Date: _____
How did you hear about our clinic? _____

X

Patient or Parent/Legal Guardian Signature_____ **Date** _____

PATIENT HISTORY

Date Completed_____

First Name _____ Last Name _____ Middle Initial _____ DOB_____

Primary concern/chief complaint: _____

Because of the above issue, what specific activities are you having difficulty with?

_____

_____

Have you experienced these symptoms before? Yes ☐ No ☐ Date(s): _____

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current pain location: _____

Current pain description: ☐ burning ☐ sharp ☐ dull/achy ☐ shooting ☐ constant

☐ numbness/tingling ☐ intermittent worse in: ☐ AM ☐ PM

custom pain description: _____

Aggravating factors: ☐ sitting ☐ standing ☐ bending ☐ sit to stand ☐ walking ☐ voiding

☐ stairs up ☐ stairs down ☐ cough/sneeze

other: _____

Please rate your pain on a scale of 0 (no pain) to 10 (worst pain imaginable):

Most pain (with this injury)	0	1	2	3	4	5	6	7	8	9	10
Current level of pain	0	1	2	3	4	5	6	7	8	9	10
Least pain (with this injury)	0	1	2	3	4	5	6	7	8	9	10

Height:_____ Weight:_____

Do you use tobacco? (circle one): Yes ☐ No ☐ If yes, how much?: _____

History of falls: N/A ☐ Yes ☐ No ☐

If yes, date(s):_____

Previous physical therapy: _____

_____

Previous surgical history: _____

_____

Do you have, or have you ever had any of the following conditions, check all that apply:

- ☐ Allergies
- ☐ Alzheimer's
- ☐ Bladder/Bowel changes
- ☐ Cardiovascular disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current infection
- ☐ Current pregnancy
- ☐ Diabetes (type I)
- ☐ Diabetes (type II)
- ☐ Dizziness/fainting
- ☐ Fibromyalgia
- ☐ Fracture
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ History of cancer
- ☐ HIV/Hepatitis
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ MRSA (staph infection)
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Psycho-social
- ☐ Respiratory problems
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Traumatic brain injury

☐ No known significant previous medical history to affect treatment

Other medical issues we should know about: _____

_____

Are you currently receiving home health care? Yes ☐ No ☐

Please list all your current medications (prescription, over the counter, herbal, vitamins/minerals):

	Dosage	Frequency	oral/injection
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____

What do you hope to improve or change with physical therapy?_____

_____

Have you had any diagnostic testing/imaging in relation to this issue? ☐ X-Rays ☐ CT ☐ MRI

Other testing: _____

Treatment side: ☐ N/A ☐ Left ☐ Right

Onset date/Injury date: _____ ☐ chronic ☐ insidious ☐ acute/new injury

Surgery performed: Yes ☐ No ☐ Date: _____Type:_____

Additional information: _____

Authorization for Release of Information And Consent to Treat

The undersigned hereby authorizes Holdrege Physical Therapy & Sports Rehab, P.C. to provide requested medical record information or excerpts to the referring Physician, Medicare, Medicaid or any other insurance company other insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing this authorization, the Patient, or Legal Guardian of the Patient hereby gives consent to medical treatment.

X

Patient or Parent/Legal Guardian's Signature **Date**

Notice of Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Holdrege Physical Therapy & Sports Rehab, P.C. is required by Federal Law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of the 1997 (HIPAA) Final Privacy Rule. We provide patient education in the form of a three page Notice of Privacy Right and Practices, however if you have any questions or desire to have further information concerning privacy practices at Holdrege Physical Therapy & Sports Rehab, please call us at (308) 534-5590.

The undersigned certifies that he/she has read our Notice of Information Privacy Practices and is the patient, or is duly authorized by or on behalf of the patient to execute the above, and accept its terms.

X

Patient or Parent/Legal Guardian's Signature **Date**

Authorization to Release Information to Family Members

Many patients allow family members such as their spouse, significant other, parents, or children to call and request medical records and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patients' consent. If you wish to have your medical information or financial information released to anybody besides yourself you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Please list the individuals you authorize Holdrege Physical Therapy & Sports Rehab to release your information to.

1. _____Relation to Patient _____
2. _____Relation to Patient _____

X

Patient or Parent/Legal Guardian's Signature **Date**

NOTICE OF FINANCIAL POLICY

Personal Health Insurance

If your treatment will be covered by your personal health insurance, please present your insurance card(s) at the time of your initial visit. Please inform our office of any changes to your insurance that may arise during your treatment. As a courtesy, we will gladly file medical claims to your insurance for you. Any copays are due at the time of your visit.

Covered benefits vary between plans, and it is important that you are aware of the benefits allowed for physical therapy under your policy. It is your responsibility to understand the limitations and exclusions of your policy. We will be glad to help you better understand your benefits, if you need assistance.

Medicare

In order to file your medical claims with Medicare, we must have written authorization from your medical Physician approving the Plan of Care. Please present your card along with your supplemental insurance at your first visit. If a balance is remaining after Medicare and supplemental insurance have paid, the balance is the responsibility of the patient.

Medicaid

The patient must provide us with a copy of their correct Heritage Health card in order for us to file claims. Share of cost amounts are the responsibility of the patient and must be paid in full. Patients, 21 years of age and older are allowed a maximum of 60 visits per calendar year. Pre-Authorization is required under all Medicaid plans.

Workers Compensation

Any patient claiming worker's compensation must bring notice from their employer to their first appointment. Worker's Compensation claims which are denied or contested become the responsibility of the patient and will be due in full or may be submitted to the patient's personal health insurance. It is the responsibility of the patient to keep our office informed of the status of the claim.

Liability Claims

As a courtesy, we will file liability claims on behalf of the patient if medical pay is available. Primary responsibility for payment however, is with the patient. Cases involving legal representation are treated as self-pay responsibility and are due at the time of service; a Medical Lien will not be filed.

Financial Agreement

As a patient and/or responsible party, you alone are responsible for payment in full of allowable expenses related to your physical therapy. **Statements are sent out on a monthly basis and are due in full upon receipt. If at any time you have to pay less than the full balance, you must contact our billing office at 308-520-8680. There is a $25.00 fee on all insufficient funds.**

- **I give my consent to Holdrege Physical Therapy and Sports Rehab to send me accounting notices through email or text messages.**

The undersigned certifies that he/she has read our financial policies and is the patient, or is duly authorized by or on behalf of the patient to execute the above, and accept its terms.

X _____ _____

Patient or Parent/Legal Guardian's Signature **Date**