FOUNDATION PHYSICAL THERAPY

PATIENT INTAKE FORM

Facility: **Leon Springs** **Boerne**	**Appointment Date:**	**Time:**	**ID#:**
Last Name	First Name	Middle Initial	Suffix

Date of Birth	Social Security #	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Street Address	City	State	Zip Code

Home Phone	Cell Phone	Email

Phone# to call for appointment reminder: ☐ Home ☐ Cell ☐ Decline Reminder type: ☐ Text or ☐ Call	Alias/Nickname (*if you are known by another name)*

Employer	Status: ☐ FT ☐ PT ☐ Retired ☐ None ☐ Student	Work Phone

Employer Address	City	State	Zip Code

Emergency Contact Name	Phone	Relationship to Patient

GUARANTOR/RESPONSIBLE PARTY INFORMATION: (if patient is responsible party, skip this section)

Name of Guarantor/Policy Holder	Date of Birth	Social Security #	Sex: ☐ Male ☐ Female

Address (Street, City State, Zip)	Phone	Relationship to Patient

Employer Name	Employer Address (Street, City, State, Zip)	Work Phone

INSURANCE INFORMATION (we must obtain copies of all insurance cards if filing with personal insurance)

Is this Personal Insurance ☐	Work Comp ☐ Claim #: Adjuster Name : Adjuster Phone:	Liability/Accident ☐ Claim #: Adjuster/Attorney Name: Adjuster/Attorney Phone:	Date of Injury: Accident Details:

Primary Insurance	Policy/I.D. #	Group #	Phone #
Secondary Insurance (*if applicable)*	Policy/I.D. #	Group#	Phone#

REFERRAL INFORMATION:

Name of Referring Physician	Phone	Post-Surgical: ☐ Yes ☐ No ☐ Unknown	Date of Surgery & Description (*if applicable)*

Diagnosis/Body Part	Prescription Date	Frequency & Duration

Have you received any prior therapy this year? ☐ Yes ☐ No (*PT, OT, Speech, or Chiropractic)*	If yes, where: How many visits:
Primary Care Physician Name, Address, and Phone (*if applicable)*	How did you hear about our clinic? ☐ Ad ☐ Sign ☐ Physician ☐ Insurance Company ☐ Website ☐ Friend/Relative ☐ Other (*please explain):*_____

MEDICARE PATIENT ONLY: Medicare reimbursement is limited to $2230 per year for Physical and Speech Therapy combined. Are you aware of any partial amount used since the first of the year? $_____

Have you received or are you currently receiving Home Health Therapy? ☐ Yes ☐ No

If yes please provide the name of the Home Health Agency:_____ Phone#:_____

By signing here I acknowledge that the information I have provided above is complete and correct.

_____ _____

(Signature of Patient/Legally Authorized Representative) (Date)

FOUNDATION PHYSICAL THERAPY

Consent and Acknowledgement Form Patient Name: _____

CONSENT FOR TREATMENT

I (**printed name**) _____ hereby authorize Foundation Physical Therapy through its appropriate personnel to provide physical therapy services to me, or the above named patient, considered necessary and proper for the assessment, diagnosing, and treatment of my/his/her physical condition. Treatment plan will be reviewed with me prior to implementation.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

FINANCIAL RESPONSIBILITY

ESTIMATED PATIENT FINANCIAL RESPONSIBILITY	Co-pay per Visit:	Co-insurance Per visit:	Deductible: Amount Remaining:	Out of Pocket: Amount Remaining:	Comments/Insurance Limitations:

As a courtesy to me Foundation Physical Therapy has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that the "Patient Financial Responsibility per visit" listed above is based on benefits obtained at the time of service and is an estimate only and not a guarantee of payment. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are ultimately my responsibility. Necessary forms will be completed to file for insurance carrier payments.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Foundation Physical Therapy for medical services rendered to myself and/or my dependents. I have requested medical services from Foundation Physical Therapy on behalf of myself and /or my dependents(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

RELEASE OF MEDICAL INFORMATION

I hereby authorize Foundation Physical Therapy to: 1.) Release any information necessary to any insurance carrier or other party which may be responsible for payment of all or part of my medical expenses regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

Information about your health and health care is filed in your medical record. This information is confidential and you control how the clinic releases this information. There may be times when it is necessary for and individual directly involved in your care to phone the facility to inquire about your personal health information or billing information. Therefore, please take a few moments to **COMPLETE** the following regarding how you wish to have this information released. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

A. I wish to allow my health information to be disclosed to the following individuals involved in my care:
NAME: **RELATIONSHIP:**
NAME: **RELATIONSHIP:**
B. I do not wish to allow my health information to be disclosed to the following individuals involved in my care:
NAME: **RELATIONSHIP:**
NAME: **RELATIONSHIP:**

_____ Date: _____

Signature of Patient/Legally Authorized Representative

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (**printed name**) _____ hereby acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices (the Notice) which explains how Foundation Physical Therapy uses and discloses my medical and billing information. The Notice also describes my rights as a patient and how I can receive additional information. I understand that I am entitled to receive a copy of this document.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

FOR OFFICE USE ONLY: REFUSAL TO SIGN ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

The following patient has been offered a copy of the Notice of Privacy Practices but has refused to sign the Acknowledgement of Notice of Practices:
Patient Name:_____ Date of Birth:_____
Reason provided by patient:_____
Employee Signature:_____
Date:_____

FOUNDATION PHYSICAL THERAPY

PHYSICAL REHABILITATION PATIENT MEDICAL HISTORY FORM

Patient Name:_____ Preferred Name:_____

What OUTCOME are you seeking here at Foundation Physical Therapy? _____

_____

List any daily activities you are having difficulty performing; list any hobbies you would like to return to:

_____

What is your chief complaint?_____ Date symptoms started _____

What is the cause of injury/condition? _____

Type of Surgery(*if applicable)*:_____ Surgery Date: _____

Rate your pain: (0=no pain, 10=unbearable pain): Pain right now: _____ at its least: _____ at its worst:_____

Describe your pain (*e.g. constant, intermittent, aching, dull, ect.)*_____

What makes your pain better?

_____

What makes your pain worse? _____

Please list all medications/supplements you are taking_____

_____

Who can we thank for referring you to Foundation? _____

In general would you say your overall health right now is: Excellent / Very Good / Good / Fair / Poor

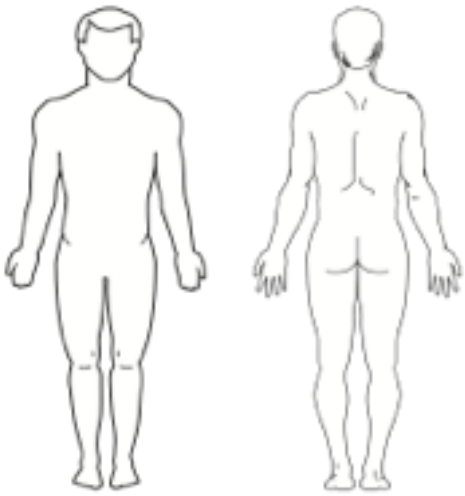
Have you had any of the following diagnostic exams?

XRAY CT SCAN MRI Results: _____

Are any of the following part of your medical history? (*Mark all that apply*)

- ☐ Heart Attacks
- ☐ Bypass/Pacemaker
- ☐ Headaches/Migraine
- ☐ High or Low Blood Pressure
- ☐ Diabetes: Diet/Insulin
- ☐ Neurological Problems
- ☐ Generalized Weakness
- ☐ Respiratory Disease
- ☐ Breast Augmentation
- ☐ Circulatory Problems
- ☐ Stroke: Right/Left
- ☐ Osteoporosis
- ☐ Incontinence
- ☐ Balance Problems
- ☐ Hearing Impairment
- ☐ Open Sores/Wounds
- ☐ Foot Problems
- ☐ Brain Trauma
- ☐ Cancer
- ☐ Neuropathy
- ☐ Arthritis
- ☐ Nausea
- ☐ Scoliosis
- ☐ Dizziness
- ☐ History of Falls
- ☐ Asthma
- ☐ Night Sweats
- ☐ Use: Tobacco/Alcohol/Recreational Drugs:_____
- ☐ Fracture: Spine/Arm/Wrist/Hip/Leg/Ankle/Other:_____

Please indicate where you have pain or other symptoms:



To the best of my knowledge and belief, the information I have given is complete and true.

_____ _____

Signature of Patient/Legally Authorized Representative Date:

ATTENDANCE POLICY

Our cancelation rate, in a large part, determines our quality of care. We do not schedule like most practices in that we do not systematically double book patients to drive productivity. We are patient driven rather than numbers driven and focus on quality, not quantity. If our cancelation rate is high then we have two options: 1.Book more aggressively (double book) and ruin our culture (not happening). 2. Make sure we enforce our cancelation policy so that the people who truly need our services can get in to see us.

- We require at least 24 hours notice to cancel and/or reschedule appointments (you are welcome to leave voice mails overnight)

- Patients who **"no-show"** or give our office **less than 4 hours**' notice when canceling an appointment will be charged a **missed appointment fee of $40.**

- This charge cannot be submitted to insurance and will be the patient's responsibility.

- **Patients that miss THREE visits, with less than 24 hours notice, during a 30 day period will have their remaining visits removed from the schedule and will be discharged.**

Our goal is to give patients an appointment time that works for them; the only way to do this is to make sure our schedule correctly reflects all appointment times that are available.

We thank you in advance for your assistance

I have read and agree to the above,

_____ _____

Signature of Patient/Legally Authorized Representative Date

_____

Patient Printed Name

Consent for Treatment of a Minor

If a patient is a minor; the parent or legal guardian must read, complete and sign the following form:
This form is required to allow us to evaluate, treat and bill for medical goods and services provided to a minor.

In my presence, or in case of my absence I consent to having Foundation Physical Therapy conduct examinations and perform procedures as are medically required and administer treatment as deemed necessary or advisable to the minor* child noted below. I understand I may request a consult with the treating therapist at any time.

I am an adult who is the:

Parent: ☐ Mother ☐ Father

Legal Guardian: ☐ Guardian

Printed name of Parent/Guardian: _____

Parent/Guardian Contact Phone Number: _____

Parent or Responsible Party's Signature:_____ Date:_____

Printed Name of Minor/Patient_____ Patients Age_____

Witness Signature_____ Date_____

Witness Printed Name_____