Patient Intake

PATIENT INFORMATION

Patient Name: ______________________________ Social Security Number: ______ - _______ - ______

Date of Birth:________________________ Gender: M F Marital Status: M D S W O

Address:___________________________________ City: ______________ State: _______ Zip: __________

Home Phone:____________________________ Cell Phone: _____________________

Work Phone: _____________ Ext: __________ Email :____

Best way to contact you: __________________ How did you hear about us? ________________________

Is this a work comp injury: _________ Is this a motor vehicle accident? _________

Can we leave messages at any of the above listed numbers?

Home: Yes No Work: Yes No Cell: Yes No

EMERGENCY CONTACT/PATIENT REPRESENTATIVE INFORMATION

Contact Name:____Relationship:________________________

Home Phone:________________________________Cell Phone:_______________________________________

Mark each purpose for which you are authorizing your protected health information to be used and/or disclosed to your emergency/representative contact:

Discussion of financial account __________

Discussion of medical status __________

Discussion of scheduling appointments __________

Other __________

Signature: ____ Date:______________

Legal Guardian:____ Date:_______________

MEDICAL HISTORY

Please circle each condition that you have been told you have (or had).

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Allergies	Asthma	Lung Disease	Hepatitis (type)___________	

Please list other medical issues not listed above:

____

____

Please list all relevant surgeries and dates:

____

____

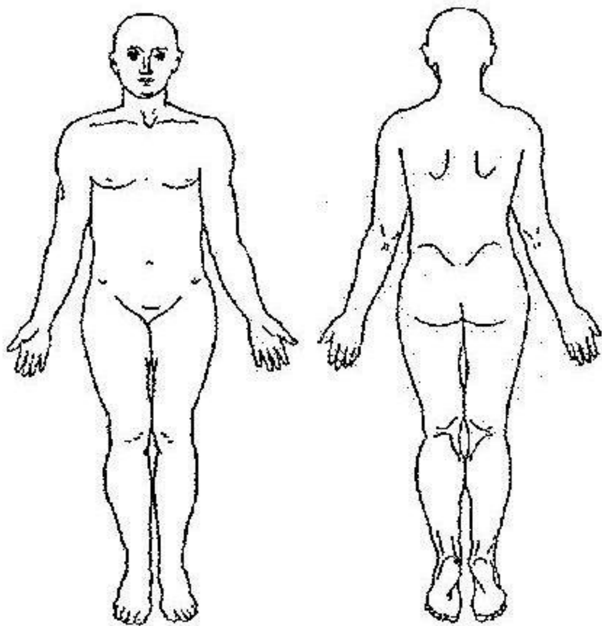
____

Are you on blood thinners?	YES	NO
Are you allergic to latex?	YES	NO
Do you have a pacemaker?	YES	NO
Are you pregnant?	YES	NO

<u>Medications:</u> **Please list current medications or provide us with a copy.**

	Name	Dosage	Frequency	Administration
1.	________________________	__________	_______________	Oral, Patch, Topical, Other
2.	________________________	__________	_______________	Oral, Patch, Topical, Other
3.	________________________	__________	_______________	Oral, Patch, Topical, Other
4.	________________________	__________	_______________	Oral, Patch, Topical, Other
5.	________________________	__________	_______________	Oral, Patch, Topical, Other
6.	________________________	__________	_______________	Oral, Patch, Topical, Other
7.	________________________	__________	_______________	Oral, Patch, Topical, Other

CURRENT INJURY



Body Diagram

Please mark on the diagram to indicate where you feel your symptoms. Use the key below to indicate the different types of symptoms.

Deep Ache= zzzz
Stabbing= ////
Numbness or tingling=0000
Burning= XXXX

On the scales below, please circle the number which best represents the severity of your pain:

Now
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable (ER)**

Best in the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable (ER)**

Worst in the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable (ER)**

When did your problem start? ____

How did your problem start? ____

What makes your symptoms worse? ____

What makes your symptoms better? ____

What do you feel is your overall functional level from 0-100%: ________

What is your overall goal for therapy? ____

Thank you for choosing Velocity Physical Therapy. We are committed to providing you with the best professional care. Your clear understanding of our policies is important to our relationship.

Consent to treatment
I hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Acknowledgment of Privacy Practices
I have read and understand the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

No Insurance/ Cash Pay
Velocity Physical Therapy offers a cash rate to those who do not have insurance coverage or those who have maximized their insurance benefits. You may make a cash payment if you do not wish to involve your insurance.

Returned Checks / Unpaid Balances
The returned check fee is $25.00. Account balances over 90 days without payment or payment agreement will accrue a 1.5% (18% annually) finance charge each billing cycle. Balances unpaid after 90 days will be turned over to a collection agency. If this is necessary, you agree to pay interest, collection fees and/or attorney fees.

Supplies
Some physical therapy supplies are not covered by insurance. If these small supplies would be of benefit to you, your therapist will give you the opportunity to opt out before incurring a charge.

Cancellation Policy
Cancellations should be made at least 24 hours prior to your appointment. If you miss an appointment without giving notice you will be charged $35. This fee is not covered by insurance.

Medical Insurance Coverage
Velocity Physical Therapy, LLC participates in most health plans, but not all. Upon your initial visit we will attempt to verify your current insurance coverage. Verification of physical therapy benefits is **NOT** a guarantee of payments. It is your responsibility to know your physical therapy benefits. All coverage is based on insurance coverage at the time of service.

Co-payments and Deductibles
As part of our contractual agreement with your insurance company we must collect co-payments and/or deductibles directly from you.

I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and myself. I understand that Velocity Physical Therapy, LLC will prepare insurance forms and bill my insurance company only as a courtesy. I understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

Patient Signature:____Date:____________________

Legal Guardian:____Date:____________________