Patient Information In-Take Sheet

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All Answers are confidential.

PATIENT INFORMATION

First Name ____________________ Last Name ______________________ Age __________ Gender ___________

Date of Birth ______________ Email Address _____________________________ Phone Number ________________

Address __________________________ City ______________________ State/Zip Code ____________________

INSURANCE AND EMERGENCY INFORMATION

Insurance Subscriber DOB _______________ Parent/Guardian or Emergency Contact # ______________________

Are you the insurance subscriber? ☐ No ☐ Yes If no, please provide full name and date of birth:

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REFERRALS AND MEDICAL HISTORY

How did you hear about us? ____

What body part will we be examining? ____

☐ Neck ☐ Back ☐ Shoulder ☐ Hip ☐ Knee ☐ Hand/ Wrist ☐ Foot/ Ankle

Any previous physical therapy for this condition? ☐ No ☐ Yes If Yes, for how long? ________________

Is this condition work related? ☐ No ☐ Yes If Yes, Please explain: _________________________________

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Is this condition due to sport injury? ☐ No ☐ Yes If Yes, Please explain: ___________________________

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Is this condition due to auto-injury? ☐ No ☐ Yes If Yes, Please explain: ____________________________

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Patient Financial Responsibilities and Insurance Information

Primary Insurance	
Secondary Insurance (if applicable)	
Deductible /Amt. Met	
Out of pocket / Amt. Met	
Co-insurance	
Co-Payment/Visit	

Your insurance information has been verified and your financial obligations are listed above. Please note, Co-payments are due **every date of service,** and may be paid by credit/debit card or personal check. Co-Insurance amounts and deductible portions are billed **monthly** to each patient and **due within 2 weeks of statement date.**

The benefits are run as a courtesy to the patients. If services are not covered, patients are responsible for the cost of treatment.

__________________ Patient Name　　__________________________ Patient Signature　　________________ Date

ABOUT YOUR MEDICARE BENEFITS:

If you are not a Medicare patient, please go to the next page.

Below are some important facts that you should be aware of regarding your Medicare Benefits for Physical Therapy.

1. This office is a participating provider for Medicare.
2. Medicare requires their beneficiaries to satisfy a $198.00 deductible for the year 2020 before they will start paying out benefits. The 2020 Medicare Physical Therapy is **$2,080.00.**
3. After your deductible is satisfied, Medicare will reimburse 80% of the Medicare approved fee. An exclusion to this would be a charge for a service that is not covered by your Medicare plan. In such a case, Medicare states that the patient is responsible for the actual charge billed by the provider.
4. In-office outpatient physical therapy benefits are limited to 80% of Medicare's fee schedule.
5. Please inform our staff if you have received any outpatient physical therapy services from another provider at any time throughout this calendar year. Failure to notify our office of PT treatment this year may result in a balance if charges are denied.

- Have you been recently hospitalized? **Y** ☐ **N** ☐
- Have you received any form of home care? **Y** ☐ **N** ☐
- If so, please specify dates ____

6. If the therapist feels that your treatment may not be covered by Medicare due to medical necessity, and you wish to continue to be treated in our office, you will be asked to fill out our waiver of liability thereby accepting payment responsibility. Payment for such services would be expected at the time of services unless prior arrangements have been made with your office.
7. After meeting the yearly deductible, the beneficiary (patient) is responsible for their co payment of 20% co-insurance at the time of service unless other arrangements have been made at our office such as a secondary insurance.

Understanding your medical benefits can be difficult, and we will make every effort to assist you when needed. If you need any further explanation of your benefit or our office policy, please feel free to speak to our office staff.

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I have read the information listed above, understand my responsibility, and certify the accuracy.

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Print Name　　　　　　　　　　　　　　　　　　　　　　　　　Date

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Signature of beneficiary

Client Credit Card Pre-Authorization

In an effort to better serve our clients and simplify your billing experience, Activa Physical Therapy has a policy of retaining current credit card information for all patients prior to initiating treatment. Your credit card information will be used in accordance with the terms below in order to pay your balance due, incuding but not limited to your deductible, co-insurance, and/or copay. The credit card information provided below will be filled with your confidential client information and will be kept secure.

_______ (Initial) I hereby acknowledge and agree that Activa Physical Therapy will send me billing statements on a monthly basis once my treatment has begun and that I have an obligation to pay each billing statement in full wishing 30 (thirty) days of the date of the billing statement.

_______ (Initial) If I have not paid a billing statement in full within 30 (thirty) days of the date of the billing statement, I hereby authorize Activa Physical Therapy to charge the full balance of my account using the credit card information provided by me below.

_______ (Initial) If I do not wish Activa Physical Therapy to charge my credit card as they have the right to do based on the paragraphs above, I agree that I will contact Activa Physical Therapy within 14 days of the date of my billing statement to discuss alternative payment arrangements, financial hardship, etc., although I acknowledge and agree that foregoing charging my credit card for my billing statement that has been paid past 30 (thirty) days from the date of the billing statement shall be in the sole discretion of Activa Physical Therapy.

Client Name: ______________________________

Client Billing Address: ______________________________

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Type of Card: ☐ VISA ☐ MasterCard ☐ DISCOVER

Card Number: ______________________________

Expiration Date: ______________ Security Code: ______________

The undersigned guarantees performance of the financial provisions of this agreement.

Card Holder Name: ______________________________

Signature of Card Holder: ______________________ Date: ______________

_______ (Initial) Being the authorized cardholder or he Corporate Officer, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. I furthermore confirm that I have received all services and goods to satisfactory conditions.

_______ (Initial) Charges made for services performed by Activa Physical Therapy are non-refundable.

Active Cancellation Policy

By signing below, you acknowledge and accept our cancellation and no-show policy: All patients are required to give 24 hours advance notice when changing or canceling an appointment as courtesy to other patients and our staff. Any appointments cancelled within less than 24 hours notice will be charged a $50 cancellation fee, unless you are able to reschedule your appointment for another day within that same week. We encourage you to stay on track with your recommended sessions per week and will work with you to make this possible.

Patients who miss an appointment and do not call to inform the facility that they will not be coming in (i.e. a NO Show) **will be charged $50/occurence.**

If you are running more than 15 minutes late to your scheduled appointment time, we reserve the right to reschedule this appointment due to other scheduling complications.

Recommended Attendace Policy

To ensure the best outcome of your Physical Therapy sessions we have in place our Recommended Attendance Policy. This requires patients to follow the specified number and frequency of sessions as recommended. To help maintain proper attendance, our company policy is to schedule out all future sessions at the time of your initial evaluation. These appointments can be changed if needed, within the timeframe of our cancellation policy. Scheduling ahead of time helps keep you on track with your physical therapy plan as discussed with our team. By signing below you acknowledge and accept our recommended attendance policy.

____________________________ Patient Signature

____________________________ Date

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by: ____
Printed Name, Patient or Representative

Relationship to Patient
(If other than patient): ____

Past Medical History Form

Patient Name: ______________________________ Date: ______________ Date of injury/onset: _______________________

Check which apply to your symptoms:

- ☐ Work related injury
- ☐ Motor Vehicle Accident
- ☐ Recurrence of previous injury
- ☐ Athletic/recreational injury
- ☐ Unknown
- ☐ Other: ______________________

Do you have or have you had any of the following symptoms/conditions?

	Yes	No		Yes	No
Diabetes			Allergies to any Medication		
Chest pain/angina			Allergies to Heat/Cold		
High Blood Pressure			Other Allergies		
Heart Disease			Hernia		
Heart Attack			Seizures		
Heart Palpitations			Metal Implants		
Pacemaker			Dizziness/Fainting		
Headaches			Recent Fractures		
Kidney Problems			Surgeries		
Are you Pregnant			Skin Abnormalities		
Cancer			Sexual Dysfunction		
Osteoporosis			Nausea/Vomiting		
Bowel/Bladder Abnormalities			Ringing in your Ears		
Urine Leakage			Rheumatoid Arthritis		
Asthma/Breathing Problems			Special Diet Guidelines		
Liver/Gall Bladder Problems			Hypoglycemia		
Do you smoke?			Epilepsy		
Stroke/CVA			Other:		

If "yes" to any of the above, please explain and provide approximate dates.

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Please indicate below where your symptoms are located:

Pain Scale 0-10:
0: None, 10: Most
____

Are you presently taking any medication? Y N
If yes, please list what medication and for what condition

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Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Activa Physical Therapy. My treatment plan has been explained to me by the treating physical therapist. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have this facility provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature ___________________________

Date __________________

Signature of Parent/ Guardian ___________________________

Date __________________