PATIENT INTAKE FORM

PATIENT INFORMATION

Today's Date:							
First Name:		Last Name:		Middle Initial:		SS#:	
☐ Male ☐ Female	Date of Birth MM/DD/YYYY		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed				
Address:	Street Address	City	State	Zip Code			
Email Address:		How would you like to receive appointment reminders?	☐ Text ☐ Email				
Phone: ☐ Cell ☐ Home ☐ Work		Alternate Phone: ☐ Cell ☐ Home ☐ Work					
Emergency Contact:		Phone:		Relationship to Patient:			

Response Physical Therapy is permitted to discuss medical records of the patient with this contact? ☐ Yes ☐ No

WORK INFORMATION

Employer:		Work Phone:	
Occupation:		Employment Status:	☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed

PHYSICIAN INFORMATION

Referring Physician:		Date of Injury:	
Referring Physician Phone:		Referring Physician Practice:	
Regular Physician/PCP:		Regular Physician/PCP Phone:	

INSURANCE INFORMATION (Provide Insurance card to receptionist)

Primary Insurance Name:			
Subscriber's Name:		Date of Birth:	
Phone #:		SS #:	
Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other			
Subscriber #:		Group/Policy #:	
Subscriber's Employer:		Phone:	

***Do you have secondary coverage? ☐ Yes ☐ No

Secondary Insurance Name:			
Subscriber's Name:		Date of Birth:	
Phone #:		SS #:	
Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other			
Subscriber #:		Group/Policy #:	
Subscriber's Employer:		Phone:	

Referral:

Chose clinic because:	☐ Doctor ☐ Insurance ☐ Family/Friend ☐ Former Patient ☐ Internet ☐ Other
Whom may we thank for your referral?	

RESPONSE PHYSICAL THERAPY

Existing or relevant previous conditions:

Have you ever been diagnosed as having any of the following conditions?

☐ Allergies	☐ Dizzy spells	☐ MRSA
☐ Anemia	☐ Emphysema/bronchitis	☐ Multiple Sclerosis
☐ Anxiety	☐ Fibromyalgia	☐ Muscular disease
☐ Arthritis	☐ Fractures	☐ Osteoporosis
☐ Asthma	☐ Gallbladder problems	☐ Parkinson's
☐ Autoimmune disorder	☐ Headaches	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hearing Impairment	☐ Seizures
☐ Cardiac conditions	☐ Hepatitis	☐ Smoking
☐ Cardiac pacemaker	☐ High/Low blood pressure	☐ Speech problems
☐ Chemical dependency	☐ High cholesterol	☐ Stroke
☐ Circulation problems	☐ HIV/AIDS	☐ Thyroid disease
☐ Currently pregnant	☐ Incontinence	☐ Tuberculosis
☐ Depression	☐ Kidney problems	☐ Vision problems
☐ Diabetes	☐ Metal implants	

Describe any other conditions:

If "Yes" to any of the above, please explain and give approximate dates/describe other conditions:

Fall History:

☐ Injury as a result of a fall in the past year?

☐ Two or more falls in the last year?

Surgical History:

Body Region:		Surgery Type:		Date:	
Body Region:		Surgery Type:		Date:	
Body Region:		Surgery Type:		Date:	
Body Region:		Surgery Type:		Date:	

Current Medications:

Drug:		Dosage:		Frequency:		Reason Taking:	
Drug:		Dosage:		Frequency:		Reason Taking:	
Drug:		Dosage:		Frequency:		Reason Taking:	
Drug:		Dosage:		Frequency:		Reason Taking:	

☐ Current not taking any medications

Exercise:

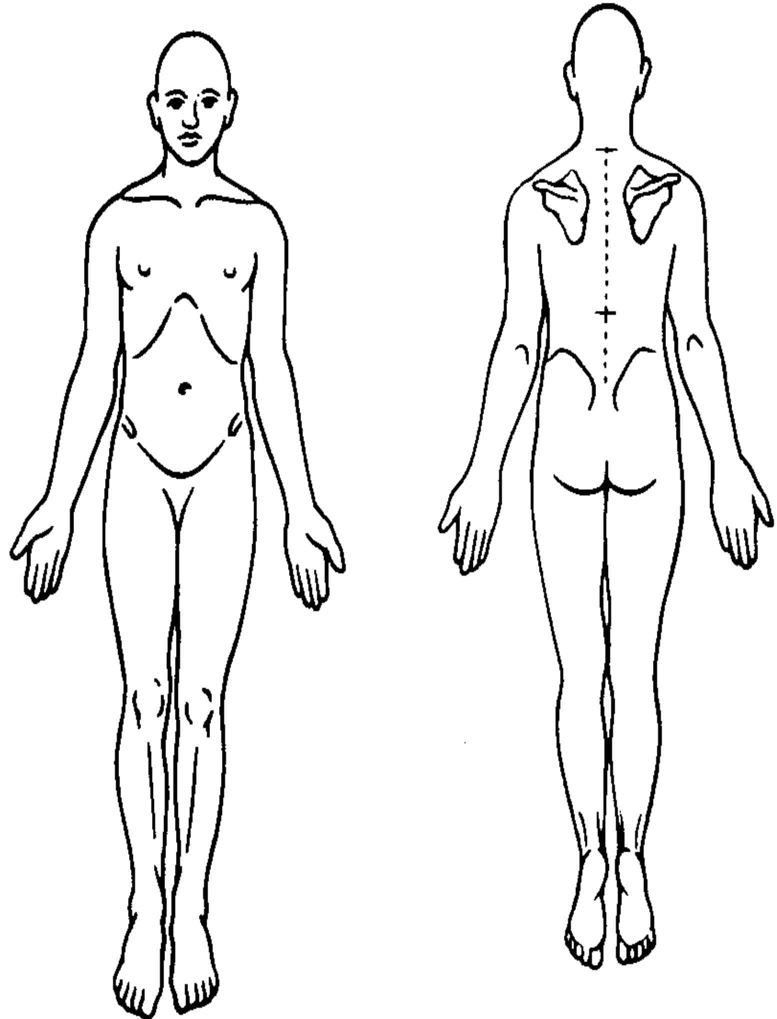
What is your exercise routine when healthy?

RESPONSE PHYSICAL THERAPY

PAIN INTENSITY SCALE

10	Pain as bad as it could be
9	Excruciating
8	
7	Severe
6	
5	Moderate
4	
3	Mild
2	Slight
1	
0	No Pain

PAIN LOCATION BODY DIAGRAMS



1. **Circle the point on the pain intensity scale at the point that best describes your pain at the present time.**
2. **Draw the location of your pain on the body diagrams above.**
3. **Please describe the details of your injury, including the date of injury and any treatment of the injury:**

Patient Name: ____

Please **read** and **initial** indicating that you are aware of and will adhere to following policies:

______**Authorization for Treatment**: I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Response Physical Therapy

______**Appointment Policy**: I understand that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three consecutive appointments, Response Physical Therapy has the right to discharge me from care for being non-compliant with my treatment plan. I understand and agree that Response Physical Therapy requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $50 charge (which is not covered by insurance)

______**Copays**: Copays are due at the time of service and will be collected at each visit

FINANCIAL POLICY AND INSURANCE INFORMATION

Please **read** the statement below and **sign** indicating understanding**:**

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and Response Physical Therapy will bill my insurance company and refund me any monies received by them from my insurance company for said supplies.

I hereby give authorization for payment of insurance benefits to be made directly to Response Physical Therapy for services rendered. In the event that my insurance company forwards payment directly to me, instead of Response Physical Therapy, I will immediately deliver said payment to Response Physical Therapy.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for Response Physical Therapy to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Signature: ____ Date: ________________

Patient and /or parent or legal guardian

Relationship to patient, if patient is under 18 years of age: ☐ Mother ☐ Father ☐ Legal Guardian

Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review carefully.

Response Physical Therapy's Legal Duty
Response Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information
Response Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Response Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Response Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purpose, for research studies, and for emergencies. We also provide information when required by law.

In any other situation, Response Physical Therapy's policies are to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Response Physical Therapy may change its policies at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practice at any time.

Patient's Individual Rights
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where to have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we may not use or disclose your personal information for treatment, payment, and administrative purposes except when specifically authorized by you,, when required by law or in emergency circumstances, Response Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints
If you are concerned that Response Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Response Physical Therapy's health information practices or if you have a complaint, please contact the following: Dan Cyr, Response Physical Therapy, 107 Edinburgh S Drive, #100a, Cary, NC 27511. Telephone: (919) 678-3286.

Signature: ____ Date: ________________
Patient and /or parent or legal guardian