# Patient Intake Form

**Demographic Information:** _____ _____

Full Name (as it appears on your insurance card) | Preferred Name/Nickname

_____ _____

Street Address | City, | State | Zip Code | Phone # Home ☐ Mobile ☐

_____ _____

Email address: we will use for sending home exercise program and clinic info | Phone# Home ☐ Mobile ☐

_____ _____ _____ _____

Date of Birth | Age | Gender | Social Security Number

Appointment Confirmation Preferred Method: ☐ Phone Call ☐ Text Message ☐ Email ☐ No reminders please

_____ _____ _____

Employer | Occupation | Working: Yes/no/modified

_____ _____ _____

Emergency Contact | Relationship | Phone

**Insurance Information:** _____ _____

Primary Insurance Carrier | Responsible Party

_____ _____

If responsible party is other than self, Primary Subscribers Name and Date of Birth | **Is this a Worker's Comp or MVA?**

_____ _____

Secondary Insurance | Subscribers Name and Date of Birth | Responsible Party

**If Worker's Comp or MVA, Please give date of injury, state of injury and claim manager info/adjuster info and claim number:**

_____

## Referring Physician:

Name of Referring Physician_____ Physician Phone # _____

## How did you hear about North Idaho Physical Therapy?

(Please Specify, so we can say "Thank you") ☐ Physician ☐ former patient ☐ sports team/coach ☐ internet ☐Other

_____ _____

Patient or Guardian Signature | Date

# Patient Medical History

Patient Name _____ Height _____ Weight _____

Type of Injury/Condition _____ Date of Injury/Onset _____

(If Applicable) Type of Surgery/Procedure _____ Date of Surgery _____

**Please describe your physical limitations as a result of this injury/surgery:** _____

**Please describe any activities or movements that aggravate your symptoms:** _____

**Please describe any treatments, movements or self-care that decrease your symptoms:** _____

**Please list any previous injury, conditions or surgeries:** _____

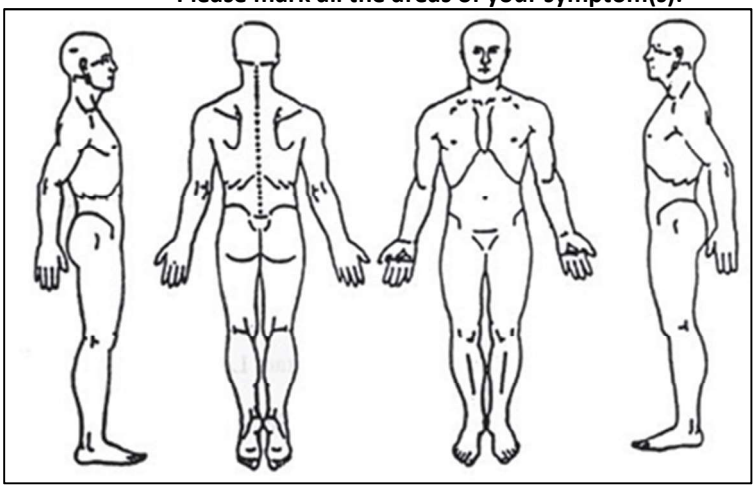
**Have you had any of the following diagnostic test in relating to this injury?** *(mark all that apply)*
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other

**Which of the following describes your pain:**
*(mark all that apply)* ☐ Sharp ☐ Achy ☐ Burning
☐ Tingling ☐ Numbness ☐ Other: _____

**Please rate your pain:** *(0= none, 5=moderate, 10= Severe)*
At present: 0 1 2 3 4 5 6 7 8 9 10
At best: 0 1 2 3 4 5 6 7 8 9 10
At worst: 0 1 2 3 4 5 6 7 8 9 10

**Are you currently taking ANY medications?** ☐ YES ☐ NO
Please list ALL medication/dosages: _____

**Please mark all the areas of your symptom(s):**



**Fall History:** Is your injury the result of a fall? ☐ Yes ☐ No Have you fallen twice or more in the past year? ☐ Yes ☐ No
Dates of falls: _____

**Health Habits and Lifestyle:**
Do you eat a well-balanced diet? ☐Yes ☐No Do you drink water regularly? ☐Yes ☐No # of glasses each day: _____
Do you smoke? ☐Yes ☐No Daily amount: _____ For how long? _____
Do you drink alcohol? ☐Yes ☐No #/day? _____ Days/week? _____
Do you exercise regularly? ☐Yes ☐No How often? _____ Type / program? _____
Do you have any hobbies/leisure activities: ☐Yes ☐No Type: _____

Patient Name _____ Date _____

**Medical History:** have you been diagnosed with any of the following conditions:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | Y | N | Diabetes | Y | N | Metal implants | Y | N |
| Anemia | Y | N | Dizziness/ringing in ears/vertigo | Y | N | Multiple Sclerosis | Y | N |
| Anxiety | Y | N | Emphysema/Chronic Bronchitis | Y | N | Neurological disorder | Y | N |
| Arthritis | Y | N | Fibromyalgia/Chronic Fatigue | Y | N | Numbness/tingling | Y | N |
| Asthma | Y | N | Fractures | Y | N | Osteoporosis/Osteopenia | Y | N |
| Bladder/Bowel problems | Y | N | Gastrointestinal Problems | Y | N | Pain Syndromes/CRPS | Y | N |
| Cancer | Y | N | Gallbladder problems | Y | N | Parkinson's | Y | N |
| Cardiac Disease/Conditions | Y | N | Headache/Migraines | Y | N | Seizures | Y | N |
| Cardiac pacemaker/ | Y | N | Hepatitis | Y | N | Speech problems | Y | N |
| Defibrillator | Y | N | Hernia | Y | N | Strokes | Y | N |
| Circulation problems | Y | N | High blood pressure | Y | N | Thyroid problems | Y | N |
| Currently pregnant | Y | N | Incontinence | Y | N | Vision problems | Y | N |
| Depression | Y | N | Kidney problems | Y | N | | | |

Please describe in detail any diagnosis marked "Y": _____

_____

_____

Have you suffered from any illness not listed here? ☐ Yes ☐ No If yes, please explain: _____

**Treatment History:**

Have you been treated for this condition before? By whom? _____

Was it helpful? ☐Yes ☐No Please explain: _____

What are your goals for Physical Therapy? _____

What do you hope to get out of your treatment? _____

What are your current physical or fitness goals? _____

Please list any important dates (such as return to sport/big performance/games coming up that you want to be ready to participate):

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

**CONSENT FOR CARE AND TREATMENT:**

I, _____ hereby agree and give my consent for North Idaho Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (initial)

FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize North Idaho Physical Therapy to treat the minor patient named in the attached forms while I am not present. _____ (parent/guardian initial)

By signing below, I agree that all of the above information is correct, and that I authorize North Idaho Physical Therapy to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment.

Patient Signature (Parent/Guardian if necessary): _____ Date: _____

# Commitment to Physical Therapy
# Late, No-Show, Cancellation and Re-scheduling Policies

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we feel it is our duty to do everything within our power to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

## Commitment to your appointments

- With the exception of serious emergencies your recovery depends upon attending all your appointments.
- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible.
- Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. We will inform your physician of the fact that your service has been discontinued due to noncompliance with the prescribed rehabilitation order.

## Late Policy

- If you are less than 15 minutes late and have contacted NIPT to warn us that you'll be late, you may complete the remaining time scheduled for your session, **knowing that you will not receive a full session**.
- If you are more than 15 minutes late and have not contacted NIPT, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a $55 fee.

## No-Show Policy

- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you $55 no-show fee.
- Reminder Calls: While we offer automated reminder calls/texts as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS. If reminder calls do not go out, and you do not show up for your appointment, you will still be charged the $55 no-show fee.

## Cancellation Policy

- If you need to cancel or reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment.
- Late Cancel: If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $55 cancellation fee.

## Paying, Cancellation, and No-Show Fees

- Cancellation and No-Show fees are not billable to any form of insurance.
- To resume treatment following a late cancel or no-show, the $55 fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to turn your care back to your referring physician.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

Patient or Guardian Signature _____ Date _____

# Payment and Insurance Policy

**FINANCIAL POLICY:**
It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, co-insurance and deductibles at the time of each visit.

**PATIENT'S RESPONSIBILTY:**
It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance status.

_____ *(Initial)*

It is the patient's responsibility to:

- Understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurances, and/or deductibles at time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescription for physical therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days previous to their 1st visit.

**INSURANCE PATIENTS**
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize North Idaho Physical Therapy to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to North Idaho Physical Therapy. _____ *(Initial)*

**MEDICARE PATIENTS** – (*please provide card)*
Have you had any PT this year provided in your home or in another outpatient clinic? ☐ Yes ☐ No _____ # of visits
Do you currently have Medicare home services? ☐ Yes ☐ No

**SELF PAY PATIENTS:**
For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. _____ *(Initial)*

**VOLUNTARY TERMINATION OF TREATMENT:**
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. _____*(Initial)*

I have read the above information and **I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT**.

_____ _____
Patient or Guardian Signature Date

# HIPAA NOTIFICATION

## Notice of Privacy Practices for Protected Health Information
## Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, North Idaho Physical Therapy is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either electronically or on paper.

**Acknowledgement (Receive HIPAA Electronically or Paper)** I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have received such Notice or have declined such Notice. I am aware that this Notice is available to me online at, North Idaho Physical Therapy's website, www.nipt.us, and I choose to receive such Notice electronically. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

**I, the undersigned, give permission to the following individual(s) to receive information about my care, cancel or change my appointments on my behalf:**

Name (s) : _____

Relationship to patient: _____

Patient Signature: _____

Date: _____