Patient Intake Form

Patient Information:

Date: _____ Patient's Name: _____
(Last) (First) (MI)

Gender:_____ Pronoun(s):_____ Birth date: ____/____/____ Married/Single/Widowed/Domestic Partnership

Home Address: _____
(Street) (City) (State) (Zip)

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Emergency Contact (_____) _____ Name/Relationship: _____

E-mail Address: _____ Soc. Sec. #: _____

Would you like a text message, phone call or an email appointment reminder? No/Yes - Text/Phone Call/email

Have you received any Physical, Occupational, Speech or Massage Therapy services in this calendar year? Y N If yes, where were the services received:

_____

Insurance Information:

Please fill out as much information as possible for accurate billing

Primary Insurance Co. _____ **Subscriber ID** _____Group # _____

Subscriber Name/DOB_____ Soc. Sec. # _____

Secondary Insurance Co. _____ **Subscriber ID** _____Group # _____

Subscriber Name/DOB _____ Soc. Sec. # _____

FOR L&I / MOTOR VEHICLE ACCIDENT CLAIMS:

Date of Injury _____ Claim # _____Physician of Record _____

Claim Manager Name/Phone # _____

Employer Name: _____Employer Phone # _____

Employer Address_____
(Street) (City) (State) (Zip)

Physician Information:

Referring Physician _____ Medical Group Name _____ Phone: _____

Primary Physician _____ Medical Group Name _____ Phone: _____

ANACORTES Physical Therapy

BURLINGTON Physical Therapy

COUPEVILLE Physical Therapy

OAK HARBOR Physical Therapy

PRE-EXAM FORM

Patient Name: _____ Height _____'_____" Weight _____

1. Where is your pain/problem? _____
2. What caused your pain/problem? _____
3. Approximately when did it start?_____
4. What is one activity you are unable to do, that you absolutely want to do again? _____
5. In your understanding, what do you think will make it better? _____
6. What are you expecting from Physical Therapy? _____
7. List any allergies you may have: _____
8. Medical History - Please circle all that apply:

A-fib
Allergies
Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's)
Arthritis
Asthma
Auto-Immune condition
Blood clots- On blood thinners?
Bowel/Bladder Problems
Cancer - Current/Past/What Type/Is treatment ongoing?
Cardiovascular Disease
Chronic Pain
Depression/Anxiety/Bi-Polar
Diabetes Mellitus Type 1 or 2
Dizzy Spells
Falls – How many in past 6 months? _____
*Fractures*_____
_____
Headaches
Hearing Problems
High Cholesterol
High/Low Blood Pressure
*Joint Replacement-When?*_____
Where? _____
Lung Disease
Motor Vehicle Accident(s) When?
_____
Multiple Sclerosis (MS)
Night Pain
Osteoporosis/Osteopenia
Pacemaker -With or without defibrillator?
Pain with Intercourse
Pain with Toileting
Parkinson's
Pregnancies
Rheumatoid Disease
Seizures-Most recent? _____
Shortness of Breath
Stroke
Thyroid Problems
Trauma History _____
_____
Unexplained Weight Loss/Gain
Vision Problems
Other: _____

9. What/If any, Diagnostic Testing have you had done on the problem area?

   X-Ray CT-Scan MRI EMG PET Scan Ultrasound

   Where did you have your Diagnostic Testing done? _____

10. Have you ever had any surgery? If so, please provide date and reason?

    _____ _____
    _____ _____
    _____ _____

11. List your medication and dosage:
    (Attach a list if necessary)

    _____ _____ _____
    _____ _____ _____
    _____ _____ _____

CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment with less than 24 hours notice, or if you are greater than 15 min. late to your appointment, it is considered a no-show.

No shows are addressed with the following policy:

1. Existing appointments will be canceled. If you would like to schedule, your appointment will be placed at the end of the current wait list.
2. In the event you no show a second time, you will not be rescheduled.

A missed appointment impacts at least 3 people.

1. You, the patient, who missed a needed therapy session.
2. Another patient who could have been scheduled in your place.
3. The therapist/owner who scheduled coverage for your appointment.

Signature_____Date_____

FINANCIAL POLICIES

We are happy to bill most insurance companies. We will do our best to verify whether outpatient physical therapy is covered by your insurance plan, and to determine the extent of coverage but ultimately it is your responsibility to know the limits and coverage of your own insurance plan**. If payment is denied by the insurance company after you have received treatment, you are responsible for the balance on your account.** If we find that your insurance plan does not cover physical therapy, we will do our best to work out a solution with you to enable you to receive the treatment that you need.

Many insurance plans require a co-payment which **we are required to collect at the time of service**. If you have any questions about financial policies or need assistance with your bill or insurance, please call and **ask for the billing manager at 360-293-2417**. Please advise us as soon as possible regarding any changes that may affect your billing, i.e. address/contact information, employment, new injury or insurance changes, or previous treatment at another physical therapy clinic.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Skagit Island Rehab Group ((SIRG) - referred to below as "the clinic")) will use and disclose **health information** about me during the provision of physical therapy. My **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to/or consult and coordinate with other health care providers in the course of my treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

CONSENT TO TREAT

- I hereby consent to treatment by SIRG.
- I understand that my appointments are subject change, and that I may be scheduled with any licensed clinician at SIRG.
- I understand that I am financially responsible for all charges and services rendered regardless of litigation insurance reimbursement or pending claims.
- I understand that the parent/guardian of a minor will be responsible for payment.
- I authorize SIRG to release any necessary information requested by my insurance carrier and authorize payment directly to SIRG for any benefits available under my insurance plan.
- I understand that SIRG is not responsible for any personal belongings I bring to the clinic.

Signature Page

Please initial that you have been offered a copy and reviewed the following forms and policies:

_____ *HIPAA*
_____ *Cancel and No-Show Policy*
_____ *Consent to Treat and Financial Release*

Patient Signature

_____

Date____/____/____

Parent/Guardian Signature if under 18

_____

Date ____/____/____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Policies but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other_____

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