RESPIRE
PHYSICAL THERAPY

5663 Columbia Pike
Falls Church, VA 22041
Office (703) 671-1871
Fax (703) 671-1790

Patient Intake Form

Referring Physician:_____ **Work Related Injury? Yes___ No___**

How did you find out about us? ☐ **Direct Mail** ☐ **Your Physician**
☐ **Social Media** ☐ **Family/Friend - Who?** _____

PATIENT INFORMATION

Legal Name:_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Date of Birth:_____ **Phone Number:** _____ **Email:**_____
SSN(required for self pay patients)**:**_____ **Patient Employed By**:_____

INSURANCE INFORMATION

Primary Insurance:_____
Secondary Insurance:_____
☐**I do not have medical insurance**

RELEASE AND ASSIGNMENT INFORMATION

Release of Medical Information: I hereby authorize Respire PT to release my medical information and/or statement of charges connected with these services to, but not limited to, an insurance carrier, workman's compensation carrier, health and welfare funds, attorneys, consultants, and anyone assisting in obtaining payment.
Insurance Assignment: I hereby assign medical benefits of any type arising out of any policy of insurance, insuring the patient or any other party liable for the patients care to, Respire PT LLC, to be applied to the charges for services rendered.
Agreement to Pay for Services: For and in consideration of the care and treatment provided to the patient, I agree to pay Respire PT for all charges for services rendered to or on behalf of the patient, including charges for insurance deductible and co-insurance which are not covered by the insurance carrier, workers compensation carrier, health and welfare funds, and fees or charges by attorneys, consultants, and anyone assisting in obtaining payment.

_____ _____
Patient Signature (or legal guardian if under 18 years old) **Date**

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MEDICAL HISTORY

Injury/Condition:_____ Surgery Date:_____ Onset Date:_____

Have you received physical therapy or Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed for this condition? Please mark all that apply:

☐X-Ray ☐CT Scan ☐MRI ☐Doppler ☐Ultrasound ☐Bone Scan

What did they show?_____

Have you recently noted:

☐Pregnant/IUD ☐Numbness/Tingling ☐Fatigue ☐Change InVision or Hearing
☐Nausea/Vomiting ☐Weakness ☐Headaches ☐Fever/Chills/Sweats
☐Pain at Night ☐Weight Loss/Gain ☐Insomnia ☐Cramps in Legs

Do you have now or have you ever had any of the following?

☐Cancer-Type_____ ☐Loss of Consciousness/Fainting ☐Fractures
☐Heart Problems/Pacemaker ☐Diabetes ☐Blood Pressure Problems
☐Surgeries-list below ☐Motor Vehicle Accident ☐Allergies/Skin Sensitivity
☐Sprains/Strains ☐Seizures ☐Hearing Difficulty
☐Circulation Problems/Clots ☐Asthma/Breathing Problems ☐Lung Disease
☐Stroke ☐Leg/Ankle Swelling ☐NONE APPLY
☐Any other medical conditions:_____

Explain & give approximate dates for any items indicated above_____

_____

Are you currently taking medications? **Yes/No**
Attach list - or - Write Name or Type of
Medication:_____

Current Pain Description

Type of Pain: Sharp/Burning/Aching/Tingling/Numbness/Other:_____
Rate your pain (average) on a scale of 1-10 (1=minimal 10=severe) Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Treatment Goals

What do you hope to get out of your treatment?_____
Is there anything else you would like to include or ask your physical therapist?_____

_____ _____
Patient Signature **Date**

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MISSED APPOINTMENT AND CANCELLATION POLICY

Respire PT requires 24 hours notice to cancel or reschedule your appointment.

Please call us at least 24 hours in advance to cancel or change a scheduled appointment. Since we reserve an hour on your therapist's schedule for each appointment at Respire PT, we expect you to make every effort to arrive on time and ready for your appointments. Late cancellations and no shows are subject to fees, which are outlined below.

Late Cancellation - Appointment is cancelled within 24 hours of scheduled appointment.

No Show - Patient does not arrive for scheduled appointment or cancels within 2 hours of appointment.

Late Arrival - Patient arrives more than 15 minutes late.

Respire PT collects fees for late cancellations and no shows at the patient's next appointment.

Fees:

- **Late cancellations – $50 second incident; $75 for third incident**
- **No shows – $75 after second incident**

*Illnesses and emergencies are handled on a case by case basis. Please speak with our Office Manager if you have any questions.

Attendance Policy:

The following situations may result in being removed from the therapy schedule and referred back to your doctor:

- **Late cancellations (after 3rd incident)**
- **No shows (after 2nd incident)**
- **Late arrivals (after 3rd incident)**
- **Excessive cancellations**

Cancelling? Please call or email the front desk at least 24 hours in advance to avoid a fee. Do not email your physical therapist to change or cancel an appointment. Monday appointments need to be cancelled by Friday.

_____ _____

Patient or Personal Representative Signature **Date**