

## Patient Intake Form

Referring Physician: \_\_\_\_\_ Work Related Injury? Yes \_\_\_ No \_\_\_

How did you find out about us?  Direct Mail  Your Physicia  
 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

## 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 In Vision 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**

## **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 – \$75 second incident; \$100 for third incident**
- **No shows – \$100 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