

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

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:

- | | | | |
|--|--|------------------------------------|--|
| <input type="checkbox"/> Pregnant/IUD | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change In Vision or Hearing |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fever/Chills/Sweats |
| <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cramps in Legs |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer-Type _____ | <input type="checkbox"/> Loss of Consciousness/Fainting | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Heart Problems/Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Pressure Problems |
| <input type="checkbox"/> Surgeries-list below | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Allergies/Skin Sensitivity |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Circulation Problems/Clots | <input type="checkbox"/> Asthma/Breathing Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Leg/Ankle Swelling | <input type="checkbox"/> NONE APPLY |
| <input type="checkbox"/> 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