Patient Intake Form

Patient Name: ____ Date: __________________

Date of Birth: ____ Gender: M ☐ F ☐

Address: ____

City: ________________________________ State: __________ Zip: ____________________

Patient Phone: Home: ________________________________

Patient Phone: Cell: ________________________________ Mobile Carrier: __________

Email Address: ____

Reminder Preference: TEXT ☐ EMAIL ☐

Diagnosis/Problem: ____

Referring MD/Physician Group: ____

MD Phone: ____ Rx Date: ________________

Onset/Injury Date: ____

How did you hear about us? ____

FINANCIAL POLICY

_____ COMMERCIAL INSURANCE: We will bill your primary and secondary insurance as a courtesy to you. We assume payment of insurance benefits is not forthcoming on charges older than 30 days. **Charges outstanding for more than thirty days will be due in full from you regardless of the type of insurance involved.** Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier.

_____ MEDICARE: We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

_____ MOTOR VEHICLE ACCIDENT: We will bill your auto insurance carrier for your charges. Please note that you will remain financially responsible for all your charges if your carrier denies coverage. For this reason, we urge you to provide your primary insurance information and we will customarily bill them for denied charges upon acknowledgement of denial.

_____ WORKERS' COMP: We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all your charges if your carrier denies coverage. We will call your worker's compensation carrier to verify existence of an open claim.

_____ LEGAL SUIT: We will accept a legal letter of protection if you meet each of the following criteria:

1) Do not qualify for benefits under any insurance policy (medical or auto), and
2) Accept a $50 prepayment charge (a portion of the full bill) per physical therapy visit, due at time of service, and
3) Are awaiting settlement and subsequent payment of damages from a related legal case, and
4) Return our lien, signed by both you and your attorney.

Upon settlement of your legal case, your balance in full is due within 30 days.

_____ CANCELLATION POLICY: To maintain appointment times available for all of our patients, there is a charge of $40.00, *BILLED TO THE PATIENT*, for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice.

☐ Checking this box indicates that the formal office HIPAA policy and procedures have been explained to the above-noted patient and that a copy of the policy was made available to the patient.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to Stride Strong Physical Therapy LLC in the event they file insurance on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therein default of payment, I accept responsibility for the principal amount owing and understand that my balance will be moved to a collections agency for collections that could eventually affect my credit score. In the event my check is returned by the bank, a processing fee of $25 will be charged to my account. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Stride Strong Physical Therapy LLC as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

____ ________________________________

AUTHORIZED SIGNATURE DATE

STRIDE STRONG PHYSICAL THERAPY

Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Name: ____ **Birth Date/Age:** ___________________________/__________
Referring Physician: __________________________________ **Family Physician:** ______________________________________
Emergency Contact Name: ____________________________ **Phone/Cell:** ____
Occupation & Employer: ______________________________ **Currently Working?** ___________________________________
Have you had surgery for this injury? **YES** **NO**
Type of surgery/dates: ____
Is an attorney involved? **YES** **NO** **Attorney Name:** ______________________________________
Are you currently taking any prescription or non-prescription medications? **YES** **NO**
Anti-Inflammatories ☐ **Muscle Relaxers** ☐ **Pain Medicines** ☐ **Others:** _________________________

Have you had any of the following Medical or Rehabilitative Care for this Injury/ Episode?

	YES	NO		YES	NO
Chiropractor	☐	☐	**CT Scan**	☐	☐
General Practitioner	☐	☐	**EMG/NCV**	☐	☐
Occupational Therapy	☐	☐	**MRI**	☐	☐
Physical Therapy	☐	☐	**Myelogram**	☐	☐
Massage Therapy	☐	☐	**X-Rays**	☐	☐
Neurologist	☐	☐	**Emergency Room Care**	☐	☐
Orthopedist	☐	☐	**Podiatrist**	☐	☐

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

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	☐	☐	**Severe or Frequent Headaches**	☐	☐
Shortness of Breath/Chest Pain	☐	☐	**Vision or Hearing Difficulty**	☐	☐
Coronary Heart Disease or Angina	☐	☐	**Numbness or Tingling**	☐	☐
Do you have a Pacemaker?	☐	☐	**Dizziness or Fainting**	☐	☐
High Blood Pressure	☐	☐	**Weakness**	☐	☐
Heart Attack/Surgery	☐	☐	**Weight Loss/Energy Loss**	☐	☐
Blood Clot/Emboli	☐	☐	**Hernia**	☐	☐
Stroke/TIA	☐	☐	**Epilepsy/Seizures**	☐	☐
Allergies	☐	☐	**Thyroid Trouble/Goiter**	☐	☐
Pins or Metal Implants	☐	☐	**Incontinence**	☐	☐
Joint Replacement (any)	☐	☐	**Bowel or Bladder Problems**	☐	☐
Diabetes	☐	☐	**Neck Injury/Surgery**	☐	☐
Infectious Diseases	☐	☐	**Shoulder Injury/Surgery**	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	**Elbow/Hand Injury/Surgery**	☐	☐
Arthritis/Swollen Joints	☐	☐	**Back Injury/Surgery**	☐	☐
Osteoporosis	☐	☐	**Knee Injury/Surgery**	☐	☐
Sleeping Problems/Difficulty	☐	☐	**Leg/Ankle/Foot Injury/Surgery**	☐	☐
Do you smoke?	☐	☐	**Multiple Sclerosis**	☐	☐
Latex Sensitivity/Allergy	☐	☐	**Parkinson's Disease**	☐	☐

Additional Comments: ____

FOR WOMEN ONLY:	YES	NO		YES	NO
Pelvic Inflammatory Disease	☐	☐	**Endometriosis**	☐	☐
Irregular Menstrual Cycle	☐	☐	**Incontinence (Urinary/Fecal)**	☐	☐
Complicated Pregnancies/Deliveries	☐	☐	**Are you Pregnant?**	☐	☐

Patient/Guardian Signature: ____ **Date:** __________________________________
PT Initials: ___________________ **Date:** _____________________________