Oliver Physical Therapy New Patient Intake Form – Private Ins/Self Pay

Initial Evaluation Date:_____ Date of Birth:_____/_____/_____

Full Name:_____Soc Sec#_____/____/_____

Address:_____

City:_____ State:_____ Zip:_____

Cell #: (____)_____ Home #: (____)_____ Work: (___)_____

Email Address:_____ Male____ Female____

Preferred Method of Contact: Call Cell:_____ Cell Text:_____ Email:_____

Emergency Contact:_____ Relationship:_____

Tele# (_____)_____

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Insurance/Financial

Self Pay_____ Medicare_____ Private Insurance_____

Primary Insurance: _____

Member ID:_____ Group #:_____

Insured's Name if Not Patient:_____

Insured's Date of Birth if Not Patient: _____/_____/_____

If Medicare Traditional, are you receiving any type of Home Health:? Yes___No___ (includes Nurse Visits, Assistance with bathing or cooking, etc.) If Yes, name of Home Health Agency:_____

Secondary Insurance:_____

Member ID:_____ Group #:_____

Insured's Name if Not Patient:_____

Insured's Date of Birth if Not Patient:_____

PLEASE GIVE THE RECEPTIONIST YOUR ID AND INSURANCE CARDS SO WE MAY COPY FOR OUR RECORDS

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New Patient Intake Form – Commercial Ins/Private Pay – Page 2

Are you: Employed_____ Student_____

Name of Employer:_____

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Referring Physician:_____

PCP or Family Physician:_____

Where is your Pain:_____

Is This From an Auto Accident: Yes___ No___ Date of Accident:____/____/_____

If Auto Accident, Do you have an Attorney: Yes___ No___

Name of Your Attorney:_____

Phone Number of Attorney:_____

Please describe as best you can, what caused your pain. Example, Fell inside or outside of home, Pulled Muscle, Do Not Know.

_____

_____

_____

_____

_____

Have you received physical therapy treatment for this condition prior to this visit:

Yes____ No____ If yes, where:_____

For Women Only: Are you pregnant: Yes_____ No_____

PATIENT CONSENT FORM

Regarding the Use and Disclosure of Health Information required by Federal Law

I understand that some of my health information may be used and /or disclosed by to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I should refer to your privacy notice entitled "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time, your privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of the notice as revised, I can call your office to request such a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke tis consent in writing, but only to the extent that your practice has not taken action in reliance thereon.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Signature:_____ Date:_____

(AGREEMENT)

I hereby direct any and all insurance carrier, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities (payers), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries or illness, past or future (condition), to pay directly to, and exclusively in the name of Oliver Physical Therapy such sums as may be owing Oliver Physical Therapy for charges incurred by me, including, but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office (charges). I further grant a contractual lien to be construed as an election by Oliver Physical Therapy to claim protection under any statutory lien law. For the purposes of this agreement, benefits shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and under insured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that in the event a payer refuses to pay, Oliver Physical Therapy hereby assign to the office, insofar as permitted by law, the following: all my rights, remedies, and benefits to Oliver Physical Therapy as well as any and all causes of action that might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection tho this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its' request.

I hereby authorize and direct Oliver Physical Therapy to file my claims with my health insurance. I understand however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, medpay, attorneys, ects.) . I hereby authorize and direct Oliver Physical Therapy to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I do agree to not hold Oliver Physical Therapy responsible or liable for any injuries that I might sustain on and/or off the Oliver Physical Therapy facility, as well as with the treatment program itself. I agree to hold Oliver Physical Therapy or employees of Oliver Physical Therapy with respect to injuries sustained at Oliver Physical Therapy facilities and property.

I hereby direct all payers to release to Oliver Physical Therapy any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this office agreement. I hereby direct this Office to file a copy of this agreement, together with any applicable charges, with any or all payers regardless of whether a claim has been established with said payers. I hereby authorize Oliver Physical Therapy to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Oliver Physical Therapy to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due to Oliver Physical Therapy for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Oliver Physical Therapy for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Oliver Physical Therapy and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Oliver Physical Therapy and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Signature:_____ Date:_____/_____/_____

Patient Name (please print):_____

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian's Signature:_____ Date:_____/_____/_____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

- ☐ Injury as a result of a fall in the past year?
- ☐ Two or more falls in the last year?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**

Date:_____Name:_____Age:___Occupation:_____

Email address: _____

When did your pain begin: _____

Do you know what caused your pain to start: _____

Describe your pain (ie: Constant, occasional, sharp, dull, numb, tingling):

_____

_____

Where is your pain: _____

When is your pain worse (time of day) or what makes your pain worse:

_____

When is your pain better (time of day) or what makes your pain better:

_____

Rate your current pain: 1 2 3 4 5 6 7 8 9 10

NO PAIN EMERGANCY ROOM PAIN

Rate your worst pain: 1 2 3 4 5 6 7 8 9 10

NO PAIN EMERGANCY ROOM PAIN

Have you ever received: X-Rays, MRI, CT Scan, Other (please circle all that apply) If Yes, what were the results:

_____

_____

Are you currently taking any medications? Please List:

_____

_____

What are your personal goals from therapy:

_____

_____

Have you ever received therapy before? If yes, what body part: _____

_____

Do you participate in any extra activities? Are you unable to participate in these because of your pain? If yes, what are the activities:

_____

_____

When is your next doctor's appointment: _____