Patient Intake Sheet

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____/_____/_____ Sex: M F Other

Address: _____ City: _____ State/Zip: _____

Phone # _____ Email: _____

Appointment reminder preference (circle one): Call Text Email

By providing us with your contact information, you are providing your express consent to allow the number/email provided to receive appointment reminders via text or automated phone call. If you choose to no longer receive these appointment reminder messages, you can inform the front office or simply follow the opt-out process (reply STOP) which will remove your number from any future appointment reminder messaging

Emergency Contact Name: _____ Phone # _____

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Insurance Information

Insurance Company Name: _____ Policy/Claim #: _____

Secondary Insurance (if applicable): _____ Policy/Claim #: _____

Received PT or Speech services this calendar year at any facility? YES / NO **How many visits? _____

Are you currently receiving services from the VNA or Home Health? YES / NO

HIPAA CONSENT

- I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews
- I have been informed that I may review the practice/clinic's Notice of Privacy Practice (for a more complete description of uses and disclosures) before signing this consent
- I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction(s), they must follow the restriction(s)
- I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed

May we discuss your medical condition with any members of your family? YES / NO

If Yes, please name: _____

May we leave a message on your phone with medical information? YES / NO

Patient Signature: _____ Date: _____

OFFICE POLICIES

CANCELLATION / NO SHOW POLICY: We will be unable to treat patients who either fail to keep appointments ("no-show") or frequently cancel appointments. **Failure to provide 24 hours' notice of cancellations may constitute a $50.00 charge. A no-show constitutes an automatic $50.00 charge before continuing therapy.**

ASSIGNMENT OF INSURANCE/RESPONSBILITY OF CHARGES INCURRED; the undersigned authorizes direct payment to Falmouth Physical Therapy of any insurance benefits otherwise payable to or on behalf of the patient for these outpatient services. It is understood by the undersigned that he/she is financially responsible for charges not covered or partially covered by insurance. **Any claims not paid by insurance within 90 days of the date of service become the patient's responsibility**. Falmouth Physical Therapy will not wait for court settlements to be reached to have bills paid unless special arrangements are made with this office prior to initiation of treatment. In cases where insurance does not cover physical therapy, payment plans can be arranged.

PATIENTS ARE RESPONSIBLE FOR:

- **Scheduling all physical therapy appointments well in advance**
- **Obtaining the required referrals and insurance authorization from your Primary Care Physician**
- **Co-payments, which are due for each visit and at the time of service**
    - **You should contact your insurance company directly to confirm your copay amount**

MEDICARE B PATIENTS: Medicare B covers physical therapy at 80%. If you wish us to bill your supplemental insurance, all insurance information must be provided at the time of your initial visit.

PERSONAL VALUABLES: Falmouth Physical Therapy does not maintain a safe for money or valuables. Falmouth Physical Therapy shall not be liable for loss of appliances, garments, or other articles of unusual value, or damage to any other physical property.

By signing, I acknowledge that I have provided accurate insurance information, have reviewed a copy of the HIPAA consent disclosure, and agree to Falmouth Physical Therapy's policies.

Patient Signature: _____ Date: _____

CLIENT HISTORY

Medical history – please check if you have/have had:

___Alzheimer's/Dementia/Memory Issues		___Cardiovascular Disease/Heart Issues
___Stroke/TIA	___Infections	___Diabetes (Type I / Type II)
___Fibromyalgia	___High Blood Pressure	___Osteoporosis
___Rheumatoid Arthritis	___Osteoarthritis	___Multiple Sclerosis
___Parkinson's Disease	___Difficulty Breathing/Lung Issues	___Traumatic Brain Injury/Concussion

___Cancer – please write type and year_____

Other: _____

Medications (dosage and frequency): _____

_____

_____

If female, is there a change you may be pregnant? YES / NO

Do you have any metal implants or a pacemaker? YES / NO

Broken Bones/Fractures (include dates): _____

Surgeries (type and year): _____

_____

Allergies: _____

INSURANCE REQUIRED SCREENING

Have you fallen in the past year? YES / NO

If you have fallen in the past year, did you sustain an injury? YES / NO

Do you feel happy most of the time? YES / NO

Have you dropped many of your activities and interests? YES / NO

Have you relied on people for bathing, dressing, shopping, banking, or meals? YES / NO

Have you been upset because someone talk to you in a way that made you feel shamed or threatened? YES / NO

Have anyone made you afraid, touched you in ways that you didn't want, or hurt you physical? YES / NO

Do you live alone? YES / NO

Do you live on one floor? YES / NO

Do you use any form of tobacco? YES / NO

EMPLOYMENT/RECREATION

Are you (circle one): Student Working Homemaker Retired

Current Employment: Job Title _____ ____Part-time ____Full-time

Hobbies/Sports: _____

CURRENT STATUS

Reason for Visit: _____

Is this condition: New Chronic

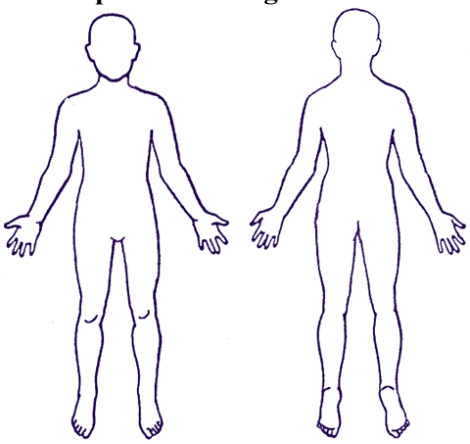
When did symptoms appear? _____ Is it getting worse? Yes No

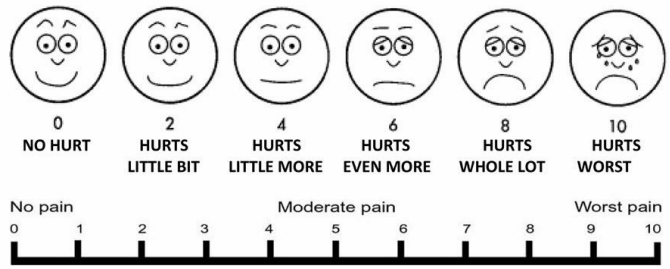
What makes the problem(s) better? _____

What makes the problem(s) worse? _____

What are your goals for physical therapy? _____

Please circle the location of your pain or where you may be having difficulty functioning and circle your level of pain on the right.





Is your problem affecting your daily activities? *Please check all that apply*

___Bed Mobility ___Walking ___Driving ___Recreation

___Shopping ___Household Care ___Dependent Care ___Self Care (bathing, dressing, etc.)

Patient Signature: _____ Date: _____