

**Intake Form**

**Patient Information**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Injury/ Onset: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F

Responsible Party Name and Relationship (for minors): \_\_\_\_\_

Address(if different from above): \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Is your overall condition improving?  Y  N Explain: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Contact Information**

Please let us know the best way to contact you (for appointment reminders)

Please check one or more of the following options:

Phone:(cell)

Phone:(home)

Phone:(work)

Email

**CONSENT TO PHYSICAL THERAPY**  
**(Please read and sign below)**

- 1. CONSENT TO TREATMENT:** I consent to rehabilitation and related services at Missing Link Physical Therapy. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.
- 2. TREATMENT OF MINORS:** I, as parent/ guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
- 3. LIABILITY:** I know and agree that Missing Link Physical Therapy is not responsible for loss or damage to personal valuables.
- 4. WAIVER and RELEASE:** I hereby release, discharge and acquit Missing Link Physical Therapy, its agents, representatives, affiliates, employees, or assigns, of any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service Emergency Medical Technician, physician or urgent care services.
- 5. AUTHORIZATION OF PAYMENT:** I consent that I will provide full payment to Missing Link Physical Therapy on services provided on that day of service.

I certify that all of the information provided herein is true and correct.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### **RELEASE OF HEALTH INFORMATION**

I give permission to Missing Link Physical Therapy to release information, verbal and written, from my medical records to my physician, insurance company, case manager, attorney, school, related healthcare provider, or other agencies as it relates to my treatment. I further authorize Missing Link Physical Therapy to obtain medical records from my physician or other medical professionals as related to my treatment.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**MEDICAL HISTORY FORM**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Have you experienced these symptoms before?  Yes  No (if yes, when?) \_\_\_\_\_

Have you had surgery related to this condition?  Yes  No

If yes, what type of surgery? \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE, OR HAD ANY OF THE FOLLOWING BELOW:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> COPD                       | <input type="checkbox"/> Ringing/ fullness in the ears                     |
| <input type="checkbox"/> Chest pain/ Angina  | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> HIV   |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis/ Osteopenia   | <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Asthma  |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Recent fractures           | <input type="checkbox"/> Anxiety   |
| <input type="checkbox"/> Vascular Disease    | <input type="checkbox"/> Headaches/ Migraines       | <input type="checkbox"/> Allergies   |
| <input type="checkbox"/> CVA/Stroke/TIA      | <input type="checkbox"/> Dizziness/Fainting         | <input type="checkbox"/> Cancer _____                                      |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Kidney Disease             | _____  |
| <input type="checkbox"/> Skin Abnormalities  | <input type="checkbox"/> Bowel/Bladder disease      | _____  |
| <input type="checkbox"/> Sexual Dysfunction  | <input type="checkbox"/> Liver/ Gallbladder Disease | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Nausea/ Vomiting    | <input type="checkbox"/> Metal Implants             | Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No     |

Please list all surgeries you have had and dates: \_\_\_\_\_

Please list all medications (attach list if needed): \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### **FINANCIAL POLICY**

Missing Link Physical Therapy is a cash Physical Therapy practice. Payment is to be provided on the date of service. We will provide the appropriate invoice so that you may submit the service provided to your insurance company for possible reimbursement.

We accept CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS and PERSONAL CHECKS.

**PLEASE NOTE THAT YOU WILL BE CHARGED \$25.00 FOR ANY CHECKS WITH NON-SUFFICIENT FUNDS.**

### **CANCELLATION POLICY**

There will be a \$35.00 fee charged to all patient's/ clients who miss scheduled appointments and fail to cancel their scheduled appointment without 24 hour notice. We understand that illness and emergencies happen and we will take that into full consideration if the situation arises and will waive the fee as necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### **Disclosure Authorization-For Release of Protected Health Information**

I have read and fully understand Missing Link Physical Therapy’s Privacy Practices. A copy of the Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Missing Link Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Missing Link Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Missing Link Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_

### **Communication of Health Information**

I give permission to Missing Link Physical Therapy to disclose and discuss any information related to my medical condition (s) with the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Initials: \_\_\_\_\_