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PHYSICAL THERAPY
Where Mind, Body & Soul Connect

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 Height:_____Weight:_____

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

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Medicare Information

Primary Insurance:

Subscribers Name: First:_____Last:_____ MI:____

Member ID#:_____

Have you had Physical Therapy services this year? □Y N

*****Please note in the event that Physical Therapy services are no longer reimbursed by Medicare you will be responsible for payment of services provided.*****

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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:_____

***** Medicare Patients ONLY *****

I request all authorized Medicare payments be made on my behalf to Missing Link Physical Therapy for services rendered to me. I also authorize release of any information to my Medicare insurer and their agents needed to determine payable benefits for services rendered.

Signature: _____ Date: _____

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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:_____

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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:

□Diabetes
□Chest pain/ Angina
□Heart Disease
□High Blood Pressure
□Heart Attack
□Pacemaker
□Vascular Disease
□CVA/Stroke/TIA
□Seizures
□Skin Abnormalities
□Sexual Dysfunction
□Nausea/ Vomiting

□COPD
□Thyroid Disease
□Osteoporosis/ Osteopenia
□Arthritis
□Hernia
□Recent fractures
□Headaches/ Migraines
□Dizziness/Fainting
□Kidney Disease
□Bowel/Bladder disease
□Liver/ Gallbladder Disease
□Metal Implants

□Ringing/ fullness in the ear
□HIV
□Hepatitis
□Asthma
□Depression
□Anxiety
□Depression
□Anxiety
□Allergies
□Cancer:_____
_____
Are you pregnant? □Yes No
Do you smoke? □Yes No

Please list all surgeries you have had and dates:_____

_____

Please list all medications (attach list if needed):_____

_____

Patient/ Guardian Signature:_____ Date:_____

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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 NONSUFFICIENT 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:_____

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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:_____