GENERAL INFORMATION:

First Name: ______________________________

Middle Name: ______________________________

Last Name: ______________________________

Preferred Name: ______________________________

SSN: ________ - _______ - _________

Birthdate: _______ / ______ / _________

Gender: Male/Female

Pronouns: He/Him, She/Her, They/Them, Prefer Not to Say

MINOR: ◯

Parent/Guardian Name: ______________________________

Address: ______________________________

Phone: ______________________________

Birthdate: ________________ SSN: ____ - ____ -

Employer: ______________________________

ADDRESS INFORMATION:

Billing Address: ______________________________

Physical Address: ______________________________

City: _________________ State: ______ Zip: ________

CONTACT INFORMATION:

Primary Phone: ____________________ Cell/Home/Work

Secondary Phone: __________________ Cell/Home/Work

Email: ______________________________

Appointment Text Reminder*: ◯

*Note by checking the text reminder box you authorize certain PHI to be disclosed (ie: name, email, appointment information)

OCCUPATION: ______________________________

Employer: ___________________ Phone: ___________

Business address: ______________________________

EMERGENCY CONTACT:

Name: ____________________ Ph: ______________

Address: _______________ Relation: ____________

Closest Relative or Friend (not living with you):

Name: ____________________ Ph: ______________

Address: _______________ Relation: ____________

MARITAL STATUS: Single/Married/Widow/Divorce

Spouse Name: ______________________________

Employer: _________________ Ph: ______________

REFERRING PHYSICIAN: ______________________

FACILITY: ______________________________

PRIMARY CARE PHYSICIAN (PCP): ______________

FACILITY: ______________________________

INSURANCE INFORMATION:

Primary Insurance: ______________________________

ID#: _________________________ Grp#: ______________

Insurance Phone #: ______________________________

Claims Address: ______________________________

Secondary Insurance: ______________________________

ID#: _________________________ Grp#: ______________

Insurance Phone #: ______________________________

Claims Address: ______________________________

CLAIM TYPE: Motor Vehicle Accident/Workman's Comp

If yes, Date of injury: ____________ State: ___________

Claim #: ______________________________

Date of Surgery (if applicable): ___________________

Do you have a follow-up appointment with the doctor who referred you to physical therapy?

- YES, date of appointment: ____________________
- NO, I am to call the doctor to schedule a follow up
- NO, doctor did not request to see me again

Restore Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered individual and the insurance company***. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

CONSENT FOR TREATMENT

I hereby consent to such physical therapy procedures as may be rendered by Restore Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Restore Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. ***A $20.00 fee will be charged for returned checks.*** Restore Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Restore Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

LESS THAN 24-HOUR CANCELLATION/NO SHOW POLICY:

It is important that you attend your scheduled appointments. It is difficult for us to assist you when you are not here. ***We do charge the patient, not the insurance a $50 fee for cancellations less than 24-hour notice and/or if you no show to your appointment. If you arrive 10 minutes or more late, your appointment will be cancelled and rescheduled and the less than 24-hour cancellation fee would be applied to your account. After 2 no shows, all future appointments will be canceled, and you will be on a call list. You will be discharged as a patient if you have 3 cancellations less than 24-hours and/or 3 no show appointments.*** Every attempt will be made to make your physical therapy appointments as convenient as possible.

HIPAA NOTIFICATION

I acknowledge that I have been informed and notified of the whereabouts of Restore Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

____

Patient or Guardian Signature **Date**

restore
PHYSICAL THERAPY

PATIENT INTAKE QUESTIONNAIRE

Name: ______________________________________ Date: ____

Preferred Name: _____________________________ Referring Physician: _________________________________

Preferred Pronouns: She/Her He/His They/Them DOB: _____________

Please describe your main problem: ____

____

When did it begin?_______________ Is it getting **(circle one)**: better / worse / staying the same

What prior treatment have you received (chiropractic, massage, etc.)? _____________________________________

____

What makes it worse? ____

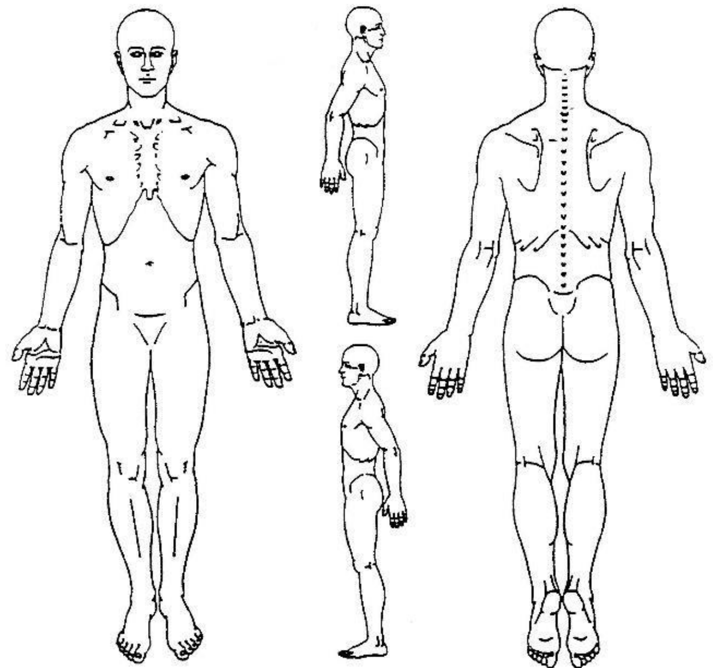
What makes it better? ____

Medical History:

Do you have or have you had the following:

	Yes	No
Cancer		
Diabetes		
Osteoarthritis		
Rheumatoid Arthritis		
Osteoporosis		
Headaches		
Ringing in Ears		
Hypoglycemia		
High Blood Pressure		
Heart Disease		
Pacemaker		
Lung Disease		
Neurological Condition (MS, Parkinson's, CVA/Stroke)		
Thyroid Condition		
Dizziness/Fainting		
Fevers/Chills		
Unexplained Weight Changes		
Bowel/Bladder Issues		
Urine Leakage		
Pelvic Pain		
Other Conditions		

Please indicate below where your symptoms are located:



KEY: numbness: ====
pins & needles: 0000
stabbing pain: / / / /
burning pain: XXXX

Pain level (0-10, 0=no pain, 10=worst pain):
Current: _____ / 10
At best: _____ / 10
At worst: _____ / 10

restore
PHYSICAL THERAPY

If you answered yes to any of the above, please explain:

____

____

Do you have any allergies? Y / N
Please explain: ____

____

Surgical History:

Spine:	Y / N	Date: __________	Hysterectomy:	Y / N	Date: __________
Shoulder:	Y / N	Date: __________	C-Section:	Y / N	Date: __________
Knee:	Y / N	Date: __________	Prostatectomy:	Y / N	Date: __________
Hip:	Y / N	Date: __________	Appendectomy:	Y / N	Date: __________
Ankle:	Y / N	Date: __________	Gall Bladder:	Y / N	Date: __________
Laparoscopy:	Y / N	Date: __________	Hernia repair:	Y / N	Date: __________

Other surgeries: ________________________________

____

Any upcoming surgeries/procedures? Y / N

____

Are you currently taking any medication/supplements (prescription or over-the-counter)? Yes____ No____
If yes, please list medications:

Medication name:	**Dosage/ frequency**	**Route (i.e.: oral, cream)**

Have you had any falls in the past 12 months? (circle one) Yes / No
If yes, how many? _________ Were you injured in the fall(s)? (circle one) Yes / No

What activities/exercise do you currently participate in? (running, swimming, yoga, golf, etc)

____

____

Which activities or tasks would you like to be able to perform that you can't currently do because of your current concern?

____

____

____

Any additional comments or concerns not addressed in this questionnaire?

____

____

Payment Policy

Private Insurance: We will verify your insurance benefits as a courtesy to you. 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(s). Insurance companies will not guarantee payment until claims are processed. Please provide the most current insurance cards. We will bill your primary and/or secondary insurance. All co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival. Any remaining balance after insurance(s) has processed is due from you upon receipt of the explanation of benefits from your insurance company (companies).

Medicare: Please provide the most current Medicare and insurance cards. We will bill Medicare and your secondary insurance (if you have one) for you. In most cases Medicare will pay 80% of the allowable charges after deductible. If you do not have a secondary insurance the balance will be billed to you. Please be advised the not all secondary insurance plans cover the deductible and co-insurance amounts. All co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival. Any remaining balance after insurances has processed is due from you upon receipt of the explanation of benefits from your insurance company (companies).

Medicaid: Please provide current Medicaid card **and** Photo Identification prior to being seen. We will verify your eligibility. Claims could be denied if you are not eligible at the time of service. If you have a cost share, it is due at the time of service.

Self-Pay: Payment for self-pay is due at the time of service. Credit cards are accepted for payment on accounts. These services cannot be billed to any insurance company. In the event you are unable to pay the balance in full, we may be able to make a reasonable payment agreement. Please be advised that Restore Physical Therapy is not a credit guarantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency.

Worker's Compensation: We will bill Worker's Compensation carrier for all charges. In the event that claims get denied for any reason you will remain financially responsible for all charges accrued during treatment. We can bill your private insurance for these services, if so all co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival.

Motor Vehicle Insurance: We will bill your insurance policy as a courtesy to you. Restore Physical Therapy does not bill 3rd party or hold balances until the settlement. A signed lien will be required. If your policy does not have Med Pay available, we can bill your personal insurance, if so all co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival. Please be advised that you will be responsible if your carrier denies the charges. Restore Physical Therapy is not a credit guarantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency. Credit cards are accepted for payment on accounts.

____ ____________________

Patient or Guardian Signature **Date**