Mind Body Physical Therapy
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# PATIENT INTAKE FORMS DATE: _____

| **PATIENT INFORMATION** - To be filled out by patient | | | | |
|---|---|---|---|---|
| **First Name:** | | **Last Name:** | | M.I.: |
| Address: | | City: | State: | Zip: |
| **D.O.B.:** / / | Age: | Male ☐ Female ☐ | SS: - - | |
| **Home Phone #:** | Mobile Phone #: | | Work Phone #: | |
| Email Address: | | | | |
| Employer: | | Occupation: | | |

| **EMERGENCY CONTACT** - To be filled out by patient | |
|---|---|
| Name: | Relationship to Patient: |
| Home Phone #: | Alternate Phone #: |

| **REFERRING INFORMATION** - To be filled out by patient | |
|---|---|
| Referred by: | Date of Injury: / / |
| First Medical Visit: | Date of Surgery: / / |

## FINANCIAL POLICY

*We are committed to providing you with the best care possible. We will be pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.*

**REGARDING INSURANCE**
Insurance is a contract between you and your insurance company. We are NOT a party to that contract in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "allowable" charges, etc., other than to supply factual information as necessary.

**I authorize my insurance company to pay Mind Body Physical Therapy directly for my care. I understand that I am responsible for all charges not covered by my insurance.**

**Deductibles and co-payment amounts are required at the time of service,** unless other arrangements have been authorized by the office manager. If payment is not received from the insurance company within 45 days, it becomes the patient's responsibility and there will be a 1.5% per month interest charge on all remaining balances. You are responsible for timely payments of your account. Should this account become delinquent, you will be responsible for all reasonable costs of collection.

**WORKER'S COMPENSATION**
We will bill your employer's industrial insurance. If your injury is determined to NOT be work related, you will be responsible for the balance due in 30 days, or we reserve the right to bill any private insurance you have.

**LIENS**
Upon verification by your attorney, we will accept your lien. The patient understands that we will be paid the full balance of our billonce the case settles.

**PATIENT NAME:** _____ **DATE:** _____

## MEDICAL SCREENING

**Do you have or have you had any of the following?**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | Spinal Disorders | ☐ | ☐ | Cancer | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Nervous Disorders | ☐ | ☐ | Stroke | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Kidney Problems | ☐ | ☐ | Seizures | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Allergies/Asthma | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Sensitivity to Heat/Ice | ☐ | ☐ | Osteoarthritis | ☐ | ☐ |
| Neck/Back Pain | ☐ | ☐ | Hernia | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Headaches | ☐ | ☐ | Metal Implants | ☐ | ☐ | Fibromyalgia | ☐ | ☐ |

**Please list all current medications:** _____

_____

## PAIN DIAGRAM & RATING

1. Please mark the **severity of pain** you are currently experiencing on a scale from 0 to 10.

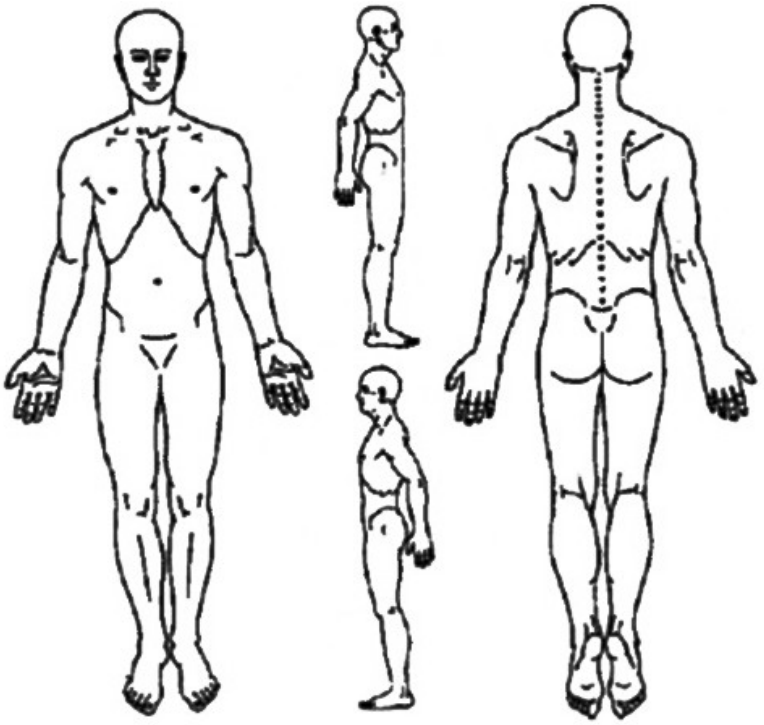
Current Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Average Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

2. Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Aching | ☐ Dull | ☐ Shooting | ☐ Swelling |
| ☐ Burning | ☐ Numbness | ☐ Stabbing | ☐ Throbbing |
| ☐ Cramps | ☐ Sharp | ☐ Stiffness | ☐ Tingling |

Other, please describe: _____



**PLEASE MARK ON THE DIAGRAM THE LOCATION OF THE PAIN AS ACCURATELY AS POSSIBLE**

**PATIENT NAME:** _____ **DATE:** _____

# Written Acknowledgement of Receipt of Notice of Privacy Practices

I, _____hereby acknowledge that I have received, read or been given the opportunity to review a copy of the Notice of Privacy Practices. I am aware that Mind Body Physical Therapy will provide a copy of the Notice of Privacy Practices at any time upon request. The Notice of Privacy Practices provides detailed information about how Mind Body Physical Therapy may use and disclose my confidential information.

**Signature:**_____ **Date:** _____

Relationship to Patient (if patient is a minor or physically or legally incapacitated): _____

# Patient Information Consent Policy

**I authorize Mind Body Physical Therapy to 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 Mind Body Physical Therapy will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions.**

# Treatment Consent Policy

**I authorize Mind Body Physical Therapy to provide any and all treatment which they, in their professional judgment, feel will help me improve. I understand that they cannot guarantee success and that some forms of treatment are painful.**

**I understand that most therapy requires my participation and that my adherence to my home program is necessary for success.**

*I acknowledge that I have read and understand ALL the above policies and that I have completed the requested information to the best of my ability.*

**Patient's Name** _____ **Patient's Signature** _____ **Date** _____
*PLEASE PRINT*

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To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated

**Patient's Name**_____ **Representative's Name** _____
*PLEASE PRINT* *PLEASE PRINT*

**Representative's Signature**_____ **Relationship/Authority to Patient** _____

**Date Signed**_____**Witness** _____

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