ELITE PHYSICAL THERAPY INTAKE FORM

PATIENT INFORMATION			
First Name:	Last Name:	Middle Initial:	Date:
Address:	City:	State:	Zip:
Birth date:	Age:	Male Female	S.S. #:
Home Phone:	Alternative Phone (Cell, Work):	Spouse:	
E-mail Address:			
Chose Clinic Because: Dr. Insurance Family/Friend Former Patient Yellow Pages Other			
Whom may we thank for your referral:			
WORK INFORMATION			
Employer:	Work Phone:	Ext.	
Occupation:	Employment Status: Full Time Part Time Retired Not Employed		
CARE PROVIDER INFORMATION			
Referring Dr:	Referring Dr. Phone:		
Regular Dr./PCP:	Regular Dr./PCP Phone:		
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)			
Primary Insurance Name:			
Subscriber's Name (If different):	Birth date :		
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: Self Spouse Child Other:			
Name of Secondary Insurance:			
Subscriber's Name:	Birth date :		
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: Self Spouse Child Other:			
AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INSUR. INFO FOR BACKUP)			
Insurance Name: Auto/Workers Comp:			
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date:	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone:	
Address	City	State:	Zip:
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:	Home Phone:	Work Phone:	

I authorize my insurance benefits be paid directly to Elite Physical Therapy I understand that I am financially responsible for any balance. I also authorize Elite Physical Therapy to release any information required to process my claims.

Patient/Guardian Signature **Date**

ELITE PHYSICAL THERAPY

Patient Medical History

To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank You!

Exercise routine when healthy: ____
____

Please check if you are currently seeing any of the following health care professionals:

Medical Doctor __________ Psychiatrist/Psychologist __________ Osteopath _____
Occupational Therapist ______ Dentist _______ Chiropractor ________

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):
____
____
____

Have you **ever** been diagnosed as having any of the following conditions? Please answer yes or no.

Cancer............................_____ If YES, describe what kind:_________________________
Heart problems.............. _____
Pacemaker......................._____
High Blood Pressure........_____
Emphysema/Bronchitis....._____
Chemical dependency......_____
Multiple sclerosis.............._____
Other arthritic conditions......_____
Diabetes................_____
Asthma..................._____
Tuberculosis..........._____
Thyroid problems..._____
Anemia.................._____
Epilepsy................._____
Allergies................._____
Depression................._____
Hepatitis....................._____
Stroke........................._____
Kidney disease..........._____
Rheumatoid arthritis...._____
Osteoporosis..............._____

Are you currently pregnant? Yes No Due Date (if yes):_____________
Have you recently experienced unexplained weight loss or gain? Yes No
Have you experienced loss of bowel or bladder control? Yes No

Are you experiencing any of the following? Please answer yes or no.
Dizziness........._____ Difficulty speaking..._____ Difficulty Swallowing........._____
Drop Attacks....._____ Double Vision........_____

List any other information which would assist us with your care:____
____
____
____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date **Surgery/Hospitalization** **Reason**

____
____
____

Please list any x-rays or imaging that you have had done: ____
____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date	Injury	Date	Injury
______	________________________	________	__________________________
______	________________________	________	__________________________
______	________________________	________	__________________________

Which of the following **over-the counter** medications have you taken **in the last week**?

_____ Aspirin
_____ Tylenol
_____ Advil/Motrin/Ibuprofen
_____ Laxatives
_____ Decongestants
_____ Antihistamines
_____ Antacid
_____ Vitamins/mineral supplements
_____ Other

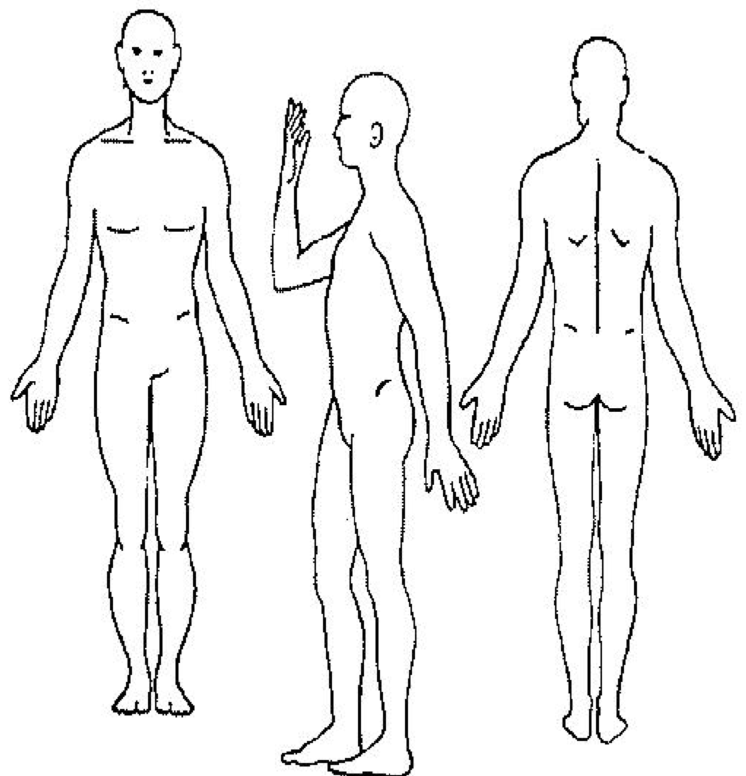
Please list any **prescription** medication you are currently taking, including pills, injections, and/or skin patches:

____
____
____

Please list the activities that aggravate your pain?

____
____

Please list your current strategies to help alleviate your pain?______________________________



Please indicate areas of pain and discomfort(on the figures above) using the following symbols:

/// = pain
*** = numbness, no feeling at all
+ + + = tingling, asleep, abnormal feeling

Please rate your pain on a scale of 0 to 10:___
(0 being no pain, 10 being the worst pain)

Elite Physical Therapy
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Phone 704.333.1052 • Fax 704.333.1054

Our Payment Policy

Thank you for choosing us as your physical therapy provider. Our goal is to provide high quality, thorough, effective treatment and care to each and every patient. In return, we ask each patient to accept responsibility for paying the fees for his or her treatment. Please read through this short policy statement and sign your name to indicate your acceptance.
At the time you receive treatment, please pay the portion of our fees which is not covered by insurance. Payment may be made by check, Visa, MasterCard, debit card(with Visa or MasterCard logo), or in cash.

We'll make a good faith effort to obtain payment from your insurer according to the information you give us, and in turn we'll expect you to pay whatever remaining balance exists when sixty days have gone by since your treatment.

If you will be unable to pay for your treatment at the time it is provided, we may be able to work out an extended payment plan with you. If a payment plan has been arranged, we may decline to schedule additional treatments until you have paid for the services already provided.

Missed appointments are a problem for us. If you realize that you won't be able to keep your appointment, please let us know as soon as possible. If you miss any of your appointments without notifying us at least 24 hours ahead, we will charge you $25.00 missed appointment fee.

Thank you for the time you've taken to read through this sheet. We ask that you sign your name below to acknowledge our payment policy.

Sign____ Date______________________

Acknowledgement of Notice of Privacy Practices
(To be retained by Medical Provider)

I understand that **Elite Physical Therapy** (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decision about and plan for my care and treatment;
- Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business function that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will bee posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of the clinic's Notice of Privacy Practices.

By:____ Date:____________________
(Patient)

- OR-

By:____ Date:____________________
(Patient representative)

Description of Representative's Authority:____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

_ Individual refused to sign
_ Communication barriers prohibited obtaining the acknowledgement
_ An emergency situation prevented us from obtaining acknowledgement
_ Other (Please specify)