

Patient In-Take Form

Name: _____ Occupation: _____ Age: _____

Primary Problem: _____

Date of Injury or Problem: _____ Referring Dr. _____

Family Dr. _____

Do you smoke or use smoke-less tobacco: Yes___ No___ Packs per day: _____

Do you consume alcohol: Yes___ No___ If yes, how often: _____

Have you ever been diagnosed with the following:

Musculoskeletal:

Fractures Yes___ No___
Metal implants Yes___ No___
Muscular Dystrophy Yes___ No___
Osteoarthritis Yes___ No___
Rheumatoid Arthritis Yes___ No___
Low Back Pain Yes___ No___
Osteoporosis Yes___ No___

Cardiovascular/Pulmonary:

Blood Clot Yes___ No___
High Blood Pressure Yes___ No___
Pacemaker Yes___ No___
Heart Disease Yes___ No___
Emphysema Yes___ No___
COPD Yes___ No___
Asthma Yes___ No___
Circulation Problems Yes___ No___

Metabolic:

Diabetes Yes___ No___
Thyroid Disease Yes___ No___
Kidney Disease Yes___ No___

Neurological:

Seizures Yes___ No___
Stroke Yes___ No___
Pins & Needles Yes___ No___
Ringing in your Ears Yes___ No___
Dizziness Yes___ No___
Blurred Vision Yes___ No___
Multiple Sclerosis Yes___ No___

Other:

Cancer Yes___ No___ Anemia Yes___ No___
Hernia / repair Yes___ No___ Depression Yes___ No___
Chronic Headaches Yes___ No___ Nervous Disorders Yes___ No___
Bowel Problems Yes___ No___ Bladder Problems Yes___ No___

Are you Pregnant: Yes___ No___

Please circle the items below if you have recently experienced any of the following:

Weight loss	Weakness	Nausea/Vomiting
Dizziness	Fever/Chills/Sweats	Night Pain
Fatigue	Numbness or Tingling	Constant Pain

Are you currently taking any medication: (prescription or over the counter) Yes___ No___

If yes, please list your medication: _____

Allergies (latex, etc) Yes___ No___ If yes, please list: _____

Have you had x-rays, CAT scans, MRI's or other tests for the reason you're attending today?

Yes___ No___ If yes, please explain the results: _____

Please list all previous surgeries, if any: _____

Do you have specific wishes for resuscitation? Yes or No _____ If yes what are they?

Has any one in your immediate family been diagnosed with the following:

Diabetes	Yes___ No___	Stroke	Yes___ No___
Heart Disease	Yes___ No___	Depression	Yes___ No___
High Blood Pressure	Yes___ No___	Blood Clot	Yes___ No___
Seizures	Yes___ No___	Cancer	Yes___ No___
Arthritis	Yes___ No___		

Do you exercise on a regular basis? Yes___ No___ If yes, please describe: _____

Please list your leisure activities: _____

Do you have difficulty getting dressed: Yes or No If yes, please describe: _____

Do you have difficulty performing activities at home (laundry, dishes, etc.): Yes or No
If yes, please describe: _____

Do you have difficulty climbing stairs? Yes or No

Do your work duties include (please circle): Please write NA if this does not apply: _____

Lifting:	Yes or No	If yes: How many pounds: _____
Climbing:	Yes or No	
Squatting:	Yes or No	
Stooping:	Yes or No	
Standing for long periods:	Yes or No	If yes: How long: _____
Reaching over head:	Yes or No	
Pushing/Pulling:	Yes or No	
Twisting:	Yes or No	

What other activities would you like to do that you are unable to at this time? _____

What are your other goals for physical therapy? _____

Is there anything else regarding your health status or current problem(s) that we should be aware of?

How did you first hear about Mountaineer Physical Therapy and Sports Medicine?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Radio | <input type="checkbox"/> Community Center | <input type="checkbox"/> Free Consult Clinics |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Mailings |
| <input type="checkbox"/> Bill Board | <input type="checkbox"/> Your Doctor | <input type="checkbox"/> TV |
| <input type="checkbox"/> Presentation | <input type="checkbox"/> New Letter | <input type="checkbox"/> Internet/Website |

Mountaineer Physical Therapy
207 Merchants Walk Plaza
Summersville, WV 26651

VERIFICATION FORM

Patient Name: _____ Phone Number: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ SS#: _____

Gender: Male Female Marital Status: S M D W Spouse's Name: _____

Employer: _____ Drivers Lic. # _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

INSURANCE INFORMATION

If you have two insurance's you need to fill in both spots

Primary Insurance Info: _____ **Relation to Patient:** _____

Name of Insured: _____ DOB: _____ SS#: _____

Policy Number: _____

Secondary Insurance Info: _____ **Relation to Patient:** _____

Name of Insured: _____ DOB: _____ SS#: _____

Policy Number: _____

IF THIS IS A WORKERS COMP INJURY PLEASE ANSWER THE QUESTIONS BELOW
IF YOU DO NOT HAVE INFORMATION PLEASE SEE SECRETARY

Claim Number: _____ Auth: _____ DOI: _____

Is Company self Insured? _____ Diag. Codes: _____

TO BE COMPLETED BY STAFF BEFORE PATIENT IS SEEN

Spoke to: _____ Date: _____ # of Visits Allowed: _____

Deductible: \$ _____ Co-pay: _____ Met: Yes / NO Amount Applied: _____

Authorization #/ Pre-cert #: _____ Out of Pocket: _____

Coverage Date's: ____Jan/Dec ____June/July Limits: _____

Any Special Information: _____ Verification Done By: _____

CONSENT FOR PHYSICAL THERAPY

Date: _____ Time: _____

1. I, _____, am entering Mountaineer Physical Therapy and Sports Medicine, INC, voluntarily for the purpose of physical therapy treatments, and do hereby consent to such treatment.
2. I hereby authorize Mountaineer Physical Therapy and Sports Medicine to complete any insurance forms and release any information, be it verbal or written, including the diagnosis and records of any treatment or examinations rendered to me, submitted to them in connection with physical therapy. This authorization is valid unless otherwise revoked, via written form, by me.
3. I agree that Mountaineer Physical Therapy and Sports Medicine shall not be liable or responsible for the loss or damage to any articles or personal property having a monetary value.
4. I understand that a payment in full for medical supplies is due at the time of treatment. I understand that payment in full for durable medical supplies is due prior to receipt of the equipment. I understand that some of the medical equipment and supplies used may not be a covered service in my insurance plan; therefore, I am responsible for those charges.
5. MPT will make every effort to provide adequate privacy. **If you feel additional privacy is necessary, please inform our staff.**
6. Comfortable clothing should be worn making it easy for treatment consisting of non revealing tops or bottoms.
7. This form has been fully explained to me, and I certify that I understand its contents.

If signing for a patient please list what relation you are to the patient
If the patient is a minor, need a parents signature.

WITNESS

Signature of patient, Guardian, or Closest Relative

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Mountaineer Physical Therapy and Sports Medicine INC, to release written or verbal information related to my current treatment for the purpose of insurance billing, physician communication, or communication to a case manager, coach, or athletic trainer.

GUARANTEE OF ACCOUNT PAYMENT

In consideration of services rendered to this patient by Mountaineer Physical Therapy and Sports Medicine, I/We absolutely and unconditionally guarantee the payment in full to Mountaineer Physical Therapy and Sports Medicine of the amount due them for said services so rendered.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Mountaineer Physical Therapy and Sports Medicine any medical benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by my insurance carrier.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS
TO PROVIDER, PHYSICIAN, AND PATIENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the organization to submit a claim to Medicare for payment to me.

I FULLY UNDERSTAND THE ABOVE INFORMATION:

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

No-Show / Cancellation Policy

The following are our policies regarding cancellations and no-shows. **We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not.** Usually your referring doctor and /or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- **We require 24 hours notice in the event of a cancellation.** It is your responsibility, when you call in to have an alternative time in mind that will ensure you get in the full-prescribed number of treatments that week. In some cases, this may not work since some forms of treatment do not work well if given two sequential days.
- **There is a \$ 15.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid personally.**

NOTE- This policy does not apply to Workers' Compensation, and Medicaid patients. For **Worker's Compensation** and Personal Injury patient's documents of **any** missed or canceled appointments are forwarded to your case manager and primary care doctor and this could jeopardize your claim, prolong or stop any benefits you may be entitled to. Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Remember, if you're in pain that is more the reason to come to your therapy appointment.

Patient Signature _____ Date _____

Interviewer _____ Date _____

PAYMENT POLICY

We offer as a service for our patients the option of billing your insurance. We will contact your insurance company on or near the initial date of service to verify coverage. However, **benefit verification is not a guarantee of payment.**

DEDUCTIBLES AND CO-PAYMENTS

Deductibles and co-payments are expected at the time of service. Unpaid balances left by your insurance companies will be your responsibility. Please contact our billing specialist if you would like to arrange a monthly payment plan.

MEDICARE PATIENTS

Medicare will pay 80% of Medicare approved charges. Please check your Medicare handbook for details.

WORKER'S COMPENSATION

Patients who are covered under Worker's Compensation are required to provide the following: exact date of injury, claim numbers, billing addresses, and any authorizations required for treatment and/or services to be rendered. You, the patient, or the authorizing party must provide these. If all of the above information is not provided, you, the patient, will be responsible for any charges incurred.

LITIGATION

Assignment forms can be provided for you and your attorney to sign guaranteeing **Mountaineer Physical Therapy and Sports Medicine** payment, in full, once your case is settled. If signatures of the attorney and patient are not obtained on the assignment form, the patient may choose from the following options: 1) bill **your** automobile or health insurance company or 2) payment in full is due at the time of service.

REMEMBER: Any unpaid balance will be the responsibility of the patient and subject to listing with a collection agency after 30 days.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call back number only

- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call back number only

- Written Communication
 - O.K. to mail to my home address
 - O.K. to mail my work/office address
 - O.K. to fax to this number _____

- Other _____

I have been offered a copy the HIPAA privacy rule. If I have any questions regarding this matter I will notify MPT in writing. I am fully aware that my PHI will not be released unless it for: Treatment, Payment, Health Care Operation (or to request other medical notes)

Patient Signature _____

Date _____

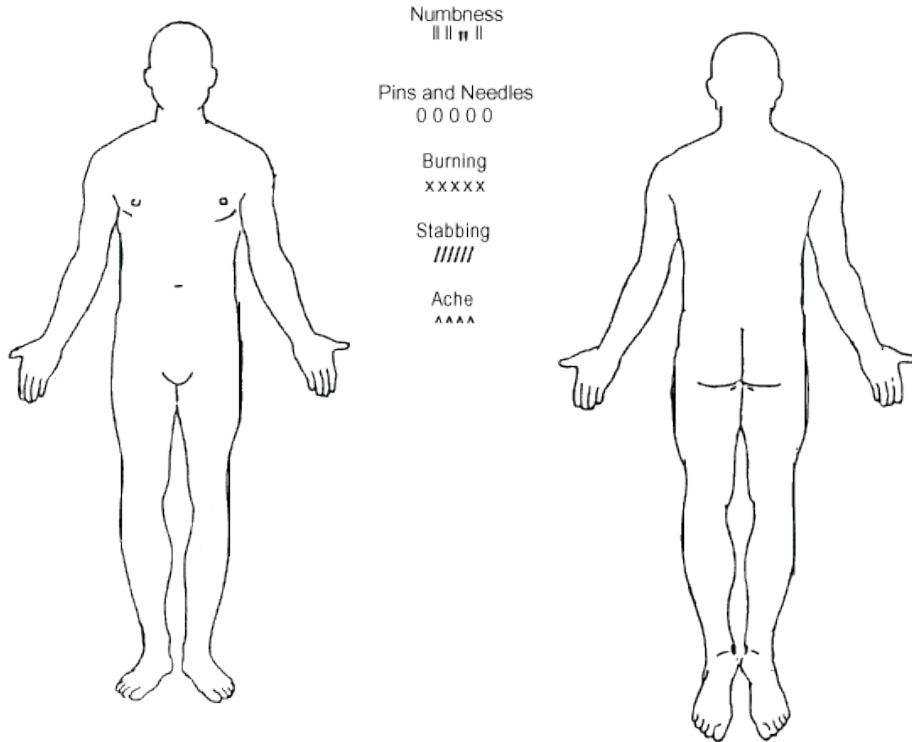
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PLEASE COMPLETE THE ENTIRE PAGE

NAME: _____

DATE: _____

Please use the following diagram below to indicate where you feel symptoms right now. Use the key below to indicate the different type of pain or location of problem.



Please use the scales below to rate your pain over the past 24 hours also rate your pain at its worst and best over the past 24 hours.

CIRCLE YOUR ANSWERS 0 = No Pain 10 = Max. Pain

Right Now: 0 1 2 3 4 5 6 7 8 9 10

Worst In Past 24 Hours: 0 1 2 3 4 5 6 7 8 9 10

Best In Past 24 Hours: 0 1 2 3 4 5 6 7 8 9 10

Comments: _____
