Providence Physical Therapy

Thank you for choosing us for your physical therapy needs. In order to best serve you, please fill out the following information in ink. Please note all of your information will be kept confidential. If you have any questions, please feel free to ask us for assistance.

Patient Information

Today's Date:_____ Date of Birth: _____
Name: _____ Email: _____
Cell Phone #: _____ Home Phone #: _____
Work Phone #:_____ Driver's License #:_____
Employer: _____ Occupation:_____
Employer's Address:_____
Street City State Zip Code

Emergency Contact Information (not living with you)

Name: _____Relationship: _____
Home Phone #: _____ Work Phone #: _____
Address: _____
Street City State Zip Code

Responsible Billing Party (if not the patient)

Name: _____Relationship:_____
Work Phone #: _____ Home Phone #: _____ SS #: _____
Employer: _____Occupation: _____
Billing Address:_____
Street City State Zip Code

Spouse Information

Name: _____Birthdate: _____SS #: _____
Employer: _____Occupation: _____
Work Phone #: _____ Cell Phone #: _____

Additional Information

When & Where are the best times to reach you? _____
How did you find out about us or whom can we thank for referring you to us? _____
_____

Cancellation Policy

Should you need to cancel an appointment we ask that at you provide us with notice at least 24 hours in advance. For failure to come to your scheduled appointment or to give advanced notice, our policy is to assess your account a minimum of $90. Please help us serve you better by keeping scheduled appointments.

Signature: _____ Date:_____

Office Information:

Account #: _____ PT: _____ Dx Codes: _____ Location: _____

PROVIDENCE PHYSICAL THERAPY

Assignment of Benefits, Consent for Release of Information, and Notice of Privacy Practice

Patient: _____ SS#/ID#: _____
Employer: _____ Claim Group: _____

Assignment of Benefits

I hereby instruct and direct _____Insurance Company to pay by check which should be made out and mailed to: Providence Physical Therapy, P. O. Box 21150, Boulder, CO 80308. However, if my current insurance policy does not allow direct payment to my provider, I hereby instruct you to make out the check to me and mail it to the following address: Providence Physical Therapy, P. O. Box 21150, Boulder, CO 80308.

This is for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy for the services rendered. I authorize Providence Physical Therapy to deposit checks received on my account when made out to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I understand that billing for services rendered is a courtesy and that it is my individual responsibility to be informed about my insurance benefits and payment obligations. All information provided to me by the administrative and billing staff of Providence Physical Therapy is the best estimate based on information provided to them by my insurance company at the time of benefit verification.

A photocopy of this Assignment shall be considered as valid and effective as the original.

Consent of Release of Information

I also authorize the release of any information pertinent to my case to any physicians, rehabilitation consultants, insurance company, adjuster, or attorney involved in this case, except as follows:

_____

Signature of Policyholder:_____Date: _____
Signature of Claimant, if other than Policyholder: _____

Please list persons with whom we may leave confidential information:

Name _____ Phone:_____
Name_____ Phone:_____

Only speak to me regarding my medical case. ☐ Yes

How may we leave confidential information with you?

Email: _____ Home Voice Mail:_____
Cell Phone Voice Mail: _____ Work Voice Mail: _____

Acknowledgement of Receipt of Notice of Privacy Practices/HIPAA

I, _____, have been provided with a copy of the Notice of Privacy Practices from Providence Physical Therapy.
Signature:_____ Date: _____

In lieu of a patient signature, I, _____, a staff member of Providence Physical Therapy, state that the above named patient was offered our Notice of Privacy Practices.

Signature:_____ Date: _____

Medical History Intake Form

To ensure 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 leave it blank and your therapist will assist you. Thank you!

Name:_____ **Occupation**:_____

Leisure Activities:_____

Allergies:
List any medication(s) you are allergic to:_____
Are you latex sensitive? YES NO
List any other allergies we should know about _____

Please check (√) any of the following whose care you are under

___ Medical doctor (MD) ___Psychiatrist/Psychologist Other _____
___ Osteopath ___ Physical 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.):_____
_____
_____

Personal Medical History:
Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind: _____
YES NO Heart Problems
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependency (i.e., alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Other_____

For Office Use

Medical History Intake Form

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Are you currently or have you in the past experienced sexual abuse? YES NO

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

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	Reason for Surgery/Hospitalization
1.	
2.	
3.	
4.	
5.	
6.	

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

Date		Date	Injury
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Describe your current general health:_____

_____

Medical History Intake Form

Family Medical History:

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Tuberculosis	YES	NO	Arthritis
YES	NO	Heart disease	YES	NO	Anemia
YES	NO	High blood pressure	YES	NO	Headaches
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Kidney disease	YES	NO	Mental illness
YES	NO	Alcoholism (chemical dependency)			

Medications:

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Other _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____
4. _____ 5. _____6._____

If you take vitamins or herbals, please list them:_____

_____

Describe your current exercise routine and/or physical activities:_____

_____

How many caffeinated coffee or caffeine containing beverages do you drink per day? _____
How many packs of cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer, one glass of wine, or one mixed drink, how much do you drink at an average sitting? _____

Have you recently noted:

YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling

_____ _____

Patient Signature Date

Obstetric Intake Form

Patient Name: _____ Date: _____

Age:_____ Height:_____ Pre-Pregnancy Weight:_____ Current Weight _____

Referring Physician:_____

Date of injury onset:_____

Is this injury the result of a motor vehicle accident? Yes ☐ No ☐

Is this injury the result of an accident while at work? Yes ☐ No ☐

Chief Complaints:_____

History/Onset of symptoms or injury (i.e. *How did you injure yourself?*):_____

_____

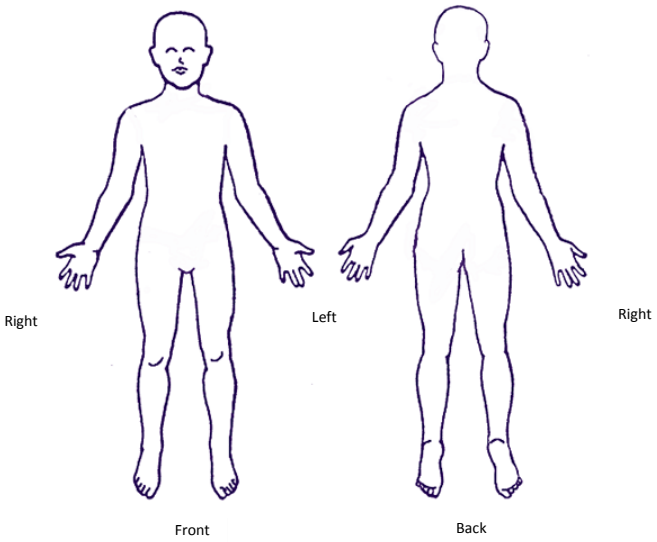
Symptoms aggravated by:_____

Symptoms relieved by:_____

Nature of pain:

†Throbbing	†Sharp †	Cramping
†Aching	†Stabbing	†Shooting
†Sore	†Burning	†Tingling

Please indicate on the diagram of the body the areas that are symptomatic. Please use x's to specify the area(s) of the body to which you are referring.



Obstetrical/Gynecological History:

Due Date**:**_____ Weeks of current gestation:_____
Number of previous pregnancies: _____
Of those pregnancies, number of live births: _____ miscarriages: _____ abortions: _____

Ages of children	Year of birth	Type of delivery (i.e. vaginal or c-section)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To allow us to provide you with the most effective, well-rounded care during your pregnancy and post-partum period, please describe any pertinent events of your previous pregnancies or deliveries that might impact this pregnancy your upcoming delivery, or your post-partum recovery. _____
_____
_____
_____
_____
_____
_____