Adams & Giddings Physical Therapy, P.C.
702 West Drake Road, E-A Fort Collins, CO 80526
P: 970.416.8342 F: 970.416.8344

PATIENT INTAKE

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **Sex:** ☐ M ☐ F **SSN:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Billing Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____ **Appointment reminder:** ☐ Email ☐ Voice ☐ Text - Which #: _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

REFERRAL INFORMATION

* ***Medicare requires a referral from a physician for physical therapy treatment. For other insurances, please check with your insurance for referral requirements.***

Diagnosis: _____ **Surgery?** ☐ Yes ☐ No **Date:** _____

Referring Doctor: _____ **Injury:** ☐ Yes ☐ No **Date:** _____

Work Accident? ☐ Yes ☐ No **Date:** _____

Primary Care Doctor: _____ **Auto Accident?** ☐ Yes ☐ No **Date:** _____

INSURANCE/BILLING INFORMATION

Will we be billing insurance? ☐ **Yes** ☐ **No** If no, then you are **Self Pay**; skip to Page 2

Do you have Medicaid? ☐ **Yes** ☐ **No** **If yes, we legally cannot provide treatment; there is no Self-Pay option**

Primary Insurance: _____ **Policyholder Name:** _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child **Policyholder DOB:** _____

ID #: _____ **Group #:** _____ **Phone:** _____

Secondary Insurance: _____ **Policyholder Name:** _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child **Policyholder DOB:** _____

ID #: _____ **Group #:** _____ **Phone:** _____

WORKERS COMPENSATION / AUTO INSURANCE INFO ONLY

Insurance Carrier: _____ **Claim #:** _____

State Accident Occurred: _____

Insurance Adjustor: _____ **Phone #:** _____ **Fax #:** _____

Employer: _____ **Employer Phone #:** _____

Employer Address: _____

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MEDICAL HISTORY / SUBJECTIVE INFORMATION

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Have you had physical therapy this year in another clinic? ☐ Yes ☐ No **If yes, how many visits?** _____

Are you currently pregnant? ☐ Yes ☐ No If YES, which trimester? _____

Do you smoke? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Arthritis**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Hepatitis**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Heart Condition	☐ Yes ☐ No	**Epilepsy**	☐ Yes ☐ No	**Respiratory Problems**	☐ Yes ☐ No
Allergies?	☐ Yes ☐ No ***List:*** _____			**Other**	_____

Overall Health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Symptoms began on: _____

Briefly describe your symptoms: _____

_____

How did your symptoms start? _____

Pain in the last 24 hours: (0-10) _____

Pain in the last week: (0-10) _____

How often do you experience symptoms?

☐ **Constant** ☐ **Frequent** ☐ **Occasional** ☐ **Intermittent**

How much have the symptoms interfered with daily activities?

☐ **Not at all** ☐ **A little bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely**

How has your condition changed, since care at this facility?

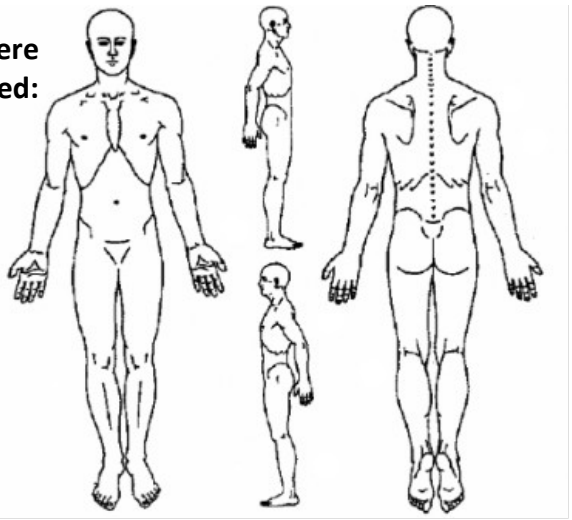
☐ **N/A (initial visit)** ☐ **Much worse** ☐ **Worse** ☐ **A little worse** ☐ **No change** ☐ **A little better**
☐ **Better** ☐ **Much better**

Please identify an important activity that you are *unable to do* or are *having difficulty with* as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy):

_____

_____

Indicate on body diagrams where your symptoms are located:



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POLICIES AND CONSENT FORM

Patient Name: _____ DOB: _____Today's Date: _____

INSURANCE: Your insurance policy is a contract between you and your insurance company. **You are ultimately responsible for payment of your copay, coinsurance, and deductible and understanding your insurance benefits.**

- ✓ **Copays, coinsurances, deductibles, and supplies are due at the time of service.** I agree to pay any charge which is denied or not paid by my insurance; this includes but is not limited to deductibles, coinsurance, and copays. I will be responsible for any cost incurred on overdue balances, including but not limited to late fees, interest fees, (18% APR), legal fees, and collection agency fees.
- ✓ Self-pay payments and supply charges are due at the time of service.
- ✓ A returned check will result in a minimum fee of $35.00.
- ✓ Please notify this office if special financial arrangements are necessary. **Only written financial agreements will be honored; no verbal or implied agreements accepted.**

CANCEL/LATE/NO SHOW POLICY: If you must cancel your appointment, a 24-hour notice is required. **If you cancel with less than 24-hour notice, we reserve the right to charge $75 per incident. You alone are responsible for this fee, not your insurance company.**

- ✓ If you arrive more than 10 minutes late for your appointment, your therapist may need to reschedule treatment, or your therapy time may be reduced.
- ✓ Failure to show for an appointment without contacting our office constitutes a **"NO SHOW FEE".** As we require adequate time to fill our schedules, you may be charged $75 per incident. **You alone are responsible for this fee, not your insurance company.**
- ✓ **Adams & Giddings Physical Therapy, P.C. reserves the right to discharge patients if there are 3 or more no-shows or cancellations within a month or in a row.**

AUTHORIZATION FOR TREATMENT: I authorize **Adams & Giddings Physical Therapy, P.C.** to treat the patient or minor patient named below, and I hereby agree to be responsible for all charges for services rendered. I understand it is up to me to inform the physical therapist about any health problems and allergies I have, and about any drugs or medications I am taking.

NOTICE OF PRIVACY PRACTICE: I have had the opportunity to review the "Notice of Health Information Practices" (Privacy Notice HIPAA privacy act) prior to signing this consent. I understand that a copy of the notice will be provided to me upon my request.

RELEASE OF INFORMATION: I authorize **Adams & Giddings Physical Therapy, P.C.,** to release any information acquired in connection with my therapy service (s), including but not limited to diagnosis and clinical records to myself, my insurance (s), physician (s) and _____.

ASSIGNMENT OF BENEFITS: I hereby authorize payment by my insurance company be made directly to **Adams & Giddings Physical Therapy, P.C.**

PHONE CALL POLICY: By signing below, you are authorizing us to call you at whatever phone numbers you provide, to include your home phone, work phone and mobile phone, regarding outstanding balances and any other matters related to your treatment at our facility.

I certify that any and all information provided by me is true. I have read the information contained in this intake form. It has been fully explained to me, if needed, and all my questions have been answered.

Print Name **Signature of patient/responsible party** **Date**