Progressive Medical Fitness

Physical Medicine & Rehabilitation

Physical Therapy

Patient Intake Form

Today's Date:	**Primary Care Physician:**

PATIENT INFORMATION

PATIENT'S LEGAL NAME: Last: First: Middle:			Date of Birth:
Street Address:	City:	State	Zip:
Email Address:			
Home Phone:	Cell Phone:	Marital Status:	
Occupation:	Employer:	Employer Phone Number:	
Referred to Clinic by:			

INSURANCE INFORMATION

Primary Insurance:	ID:	Group Number:
Deductible:	Co-pay:	Coinsurance:
Subscriber's Name	Relationship:	Subscriber DOB:
Secondary Insurance (if applicable):	ID:	Group Number:
Deductible:	Co-pay:	Coinsurance:
Subscriber's Name	Relationship:	Subscriber DOB:
Tertiary Insurance (if applicable):	ID:	Group Number:
Deductible:	Co-pay:	Coinsurance:
Subscriber's Name	Relationship:	Subscriber DOB:

IN CASE OF EMERGENCY

Name (Last, First):	Relationship to patient:	Phone Number:

The above information is true to the best of my knowledge. I authorize release of information requested by my insurance plan for payment. I hereby consent and authorize al therapy treatments at Progressive Medical Fitness.

Patient/Guardian signature

Date

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Patient Medical History

Patient Name:	**Date:**	**Date of Birth:**

MEDICAL HISTORY

Do you have a history of any of the following?

	YES	NO		YES	NO
High Blood Pressure			**Liver Problems**		
Heart Disease			**Kidney Problems**		
Pacemaker			**Speech Problems**		
Strokes			**Sensitivity to Cold**		
Seizures			**Sensitivity to Heat**		
Cancer			**Dizzy Spells**		
Diabetes			**Metal Implants**		
Osteoarthritis			**Allergies**		
Fibromyalgia			**Fractures**		
Circulation Problems			**Vision Problems**		
HIV or AIDS			**Hearing Problems**		
Lupus			**Are you pregnant?**		

Have you suffered from any illnesses not listed above? (If yes, please explain) Yes ◯ / ◉ No

Have you fallen in the last year? Yes ◯ / ◯ No

Have you ever had surgery including this current condition? Yes ◯ / ◯ No

Type of Surgery:	Date of Surgery:

REASON FOR PHYSICALTHERAPY

Describe the history of your present condition. Please provide all important details:

What body part are we treating?

Date of Injury:	Are we treating you as a result of a fall? ◯ Yes ◯ No	Have you fallen twice or more in the last year? ◯ Yes ◯ No

Have you had therapy for your current condition? ◯ Yes ◯ No	Location:	Dates:	# of Visits:

What are your goals or expectations for therapy?

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PATIENT MEDICATION RECORD

Medication / Allergy History	
Allergies/Sensitivities (drugs, herbs, foods, dye, latex, tape, etc.)	Reaction:

Medication/Drug	Dose	Route	Frequency	Reason

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Informed Consent for Physical Therapy Services

Physical Therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin or disability. The purpose of physical therapy is to treat disease, injury and disability by examination evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Progressive Medical Fitness cannot guarantee what your reaction will be to a specific treatment, nor can it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

Please note the following patient rights:

1. It is your right to decline any part of your treatment at any time before or during treatment should you feel any discomfort or pain or have other unresolved concerns.
2. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.
3. It is your right to discuss the potential risks and benefits involved in your treatment.

By signing below, I agree that I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

I authorize the release of my medical information to appropriate third parties.

Patient Name:_____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____

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Patient Financial Agreement

Keeping the lines of communication open with all of our patients on all matters is a key focus of Progressive Medical Fitness. The following are the financial policies and expectations of our office. Please read this section carefully and sign below. If you have any questions, please ask our office staff for clarification.

- Upon arrive to our office, we will verify your insurance coverage. However, it is the responsibility of you, the patient, to be aware of your benefit details. According to all insurance carriers, **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE OR PAYMENT.** This means that you, the patient or guarantor, are ultimately responsible for the cost of your treatment.

- All visit payments are due before the start of your treatment each visit.

- We do our best to estimate the amount that your insurance plan will apply to your deductible, copay and/or co-insurance or hold you, the patient, responsible for each visit. If your insurance company deems you responsible for an amount that differs from what we estimated, this will be considered your, the patient's responsibility and will be billed to you, the patient.

By signing below, I agree that I have read and understand this patient financial agreement. I agree to company and accept responsibility to the terms outlined above.

Patient Name:_____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____

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Notice of Patient Information Privacy Practices

Legal Duty

Progressive Medical Fitness is required to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Progressive Medical Fitness uses your personal health information primarily for treatment, obtaining payment for treatment, and evaluating the quality of care that we provide, as well as for internal administrative activities, for example, we may use your personal health information to contact you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related services that could be of benefit to you.

Progressive Medical Fitness may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release our information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Progressive Medical Fitness may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted and/or you may request an updated copy of our Notice of Patient Information Privacy Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information for reasons other than treatment, payment or other related purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or emergency circumstances.

Concerns and Complaints

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer. You may also send a written complaint to the US Department of Health and Human Services.

I have read and fully understand Progressive Medical Fitness's Notice of Patient Information Practices. I understand that Progressive Medical Fitness may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluation 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 hereby consent to the use and disclosure of my personal health information for purposes as noted in Progressive Medical Fitness's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Patient Name (Print) | If not patient, Relationship to Patient