PHYSICAL THERAPY OF BOULDER – PATIENT INTAKE FORM

Patient Information:		
Last Name:	First Name:	Social Security Number:
Mailing Address:	Home Phone ( )	Other Phone ( )
City State ZIP	Email Address:	Date Of Birth : Sex:

Guarantor Information:			
Guarantor Name (If patient is a minor):	Relationship To Patient:	Date of Birth	Social Security Number:
Address:	City State Zip		Contact Phone # ( )

Emergency Contact:		
Name:	Relationship To Patient:	Contact Phone # ( )

Accident Information:					
Is this injury the result of an open Work Comp claim?	Yes	No	Is this injury the result of an open Auto claim?	Yes	No

Primary Insurance Information:		
Primary Insurance:	Subscribers Date of Birth:	ID Number or Claim Number:
Subscribers Name:	Relationship To Patient [ ] Self [ ] Spouse [ ] Parent/Guardian	

Secondary/Supplemental Insurance Information		
I AM [I AM NOT [ ]COVERED BY A SECONDARY INS.]	Secondary Insurance:	ID Number or Claim Number:
Subscribers Name:	Subscribers Date of Birth:	Relationship To Patient: [ ] Self [ ] Spouse [ ] Parent/Guardian

Office Policy:

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed specifically for you using a variety of treatment techniques.
I, the undersigned, do hereby agree and give my consent for Physical Therapy of Boulder to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Physical Therapy of Boulder to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

HIPAA - NOTICE OF PRIVACY PRACTICES: By my signature below, I acknowledge that I have read and understand the HIPAA privacy practices set by this clinic and the Secretary of Health and Human Services. I understand that I will be given a copy of the HIPAA notice upon my request.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $75.00 for physical therapy or wellness program visits and the full price of a massage or Pilates visit. This charge **will not be covered** by insurance, but **will have to be paid in full by you**.

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize Physical Therapy of Boulder to treat the minor patient named above while I am not present.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today prior to any additional treatments. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for a penalty of 50% of the open balance to cover collections
agency fees. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. I hereby authorize Physical Therapy of Boulder to leave a message with any information regarding insurance benefits.

Who may we talk to about your account? (Billing and Scheduling)	Name Relationship

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient / Guardian Signature _____ Date_____

PHYSICAL THERAPY OF BOULDER – PATIENT INTAKE FORM

Patient name:_____

History of Present Condition:

What is your primary complaint that brings you to Physical Therapy?

_____

Did you have surgery? What type? _____ Surgery date? _____

When did your symptoms begin? _____

What treatment have you received so far? _____

Since onset are symptoms getting: □ better □ worse □ not changing

What aggravates your symptoms? _____

What alleviates your symptoms? _____

Medication:

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc):

_____

Do you have any allergies? _____

General Health:

How would you rate your general health?

□ Excellent □ Good □ Average □ Poor

Past Medical History

Have you ever been diagnosed with any of the following conditions? (check all that apply)

□ Cancer (type) _____
□ Depression
□ Stroke
□ Kidney problems
□ Thyroid problems
□ Diabetes
□ Multiple Sclerosis
□ Head injury
□ Stomach problems
□ Parkinson's disease
□ Infectious diseases (type) _____
□ Arthritis
□ Heart problems
□ High blood pressure
□ Lung problems
□ Blood disorders
□ Epilepsy/seizures
□ Allergies
□ Rheumatoid arthritis
□ Osteoporosis
□ Broken bones
□ Circulation/vascular
□ Other _____

Are you on Blood Thinners? _____
Do you have a pacemaker? _____
Are you pregnant or trying to get pregnant? _____

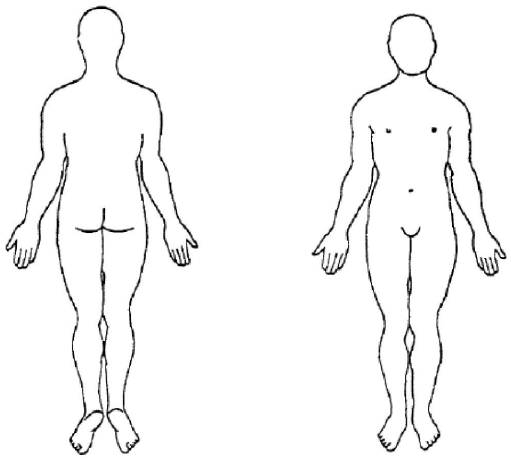
Using the 0 to 10 scale, with 0 being "no pain" and 10 being "the worst pain imaginable," please describe:

Your current level of pain while completing this survey: _____
The best your pain has been during the past week: _____
The worst your pain has been during the past week: _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



PHYSICAL THERAPY OF BOULDER – PATIENT INTAKE FORM

Credit Card Policy

I authorize Physical Therapy of Boulder (PTOB) to automatically charge my credit card (Visa, Mastercard) listed below for the reason listed below.

Patient Initial	By initialing I acknowledge that my credit card will be run automatically, at time of service, for copay, coinsurance or deductible.

Patient Name: _____

Cardholder Name as it appears on card (Please Print): _____

Cardholder Address (Please Print): _____

City, State, Zip (Please Print): _____

Circle one: Visa MasterCard Discover HSA (Health Savings Account)

Card # _____

Expiration _____

(Please call the office at 303-938-1141 with any questions)

[ ] I would like receipts emailed to me. Email Address: _____

Balances under $500 will automatically be charged.

If your balance is over $500, we will notify you prior to running your credit card.

_____*Initial if okay to leave a message.*

Phone Number: _____

Authorized Signature: _____ Date: _____

*This authorization is to remain in effect until I cancel it in writing.