Knob Noster
Physical Therapy

Patient Intake Form

Patient Information

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____
Apt. or P.O Box _____ Zip Code _____ Date of Birth _____ Gender _____
Home Phone _____ Cell Phone _____ E-mail _____
SSN _____ E-mail or Text Appointment Reminders _____

Emergency Contact

Last Name _____ First Name _____
Relationship _____ Phone _____

Employer (Work Comp)

Name _____ Phone _____
Address _____
City _____ State _____ Zip Code _____

Insurance Information

Primary Insurance Name _____

Secondary Insurance Name _____

Acknowledgment

I authorize release of information requested by my insurance plan for payment.

I understand that I am financially responsible for any balance due.

I agree to comply with the terms and conditions outlined on the Consent to Treatment form.

(You have the right to refuse to sign this acknowledgement if you so choose)

Signature _____ Date _____

Witness _____ Date _____

Knob Noster
Physical Therapy

Patient Cancellation & No-Show Policy

Your scheduled appointment is a specific time that your therapist will spend with you. We will attempt to be as flexible as possible with scheduling your appointments. Your therapist attempts to be respectful of your time by starting your treatment as scheduled. Please help up maintain this schedule by arriving on time. If you are unable to arrive on time for your appointment, please call and reschedule. If you are more than 15 minutes late for your scheduled appointment, we may need to reschedule your appointment.

Cancellations of three consecutive or non-consecutive appointments will result in the removal of any remaining appointment, future appointments scheduled accordingly. Failure to attempt three consecutive appointments will result in termination of your therapy program. To restart your therapy, you must return to your physician for a new prescription and obtain additional authorization from your insurance company. Knob Noster Physical Therapy reserves the right to contact all active duty members supervisors in the event of 3 or more no show and/or cancelled appointments.

IN THE EVENT THAT YOU ARE COVERED BY WORKER'S COMPENSATION and fail to keep the appointments as recommended by your physician, the appropriate parties will be notified of your absence in writing. Typically, the notification will be to your physician, insurance carrier, employer and rehabilitation consultant. Each cancelled and no/show appointment will also be noted in your chart. Please understand that failure to actively participation in your rehabilitation program may result in the impression that you are disinterested in your recovery and are better and able to return to work. Failure to attend therapy may have a negative effect on your workers' compensation coverage.

Thank you for your assistance.

If Patient is under 18 Parent or Guardian Must Sign for Patient

Signature _____ Date _____

Parent or Guardian Signature _____

Parent or Guardian Printed Name _____ Relationship to Patient _____

Knob Noster
Physical Therapy

Patient Rights & Responsibilities

1. The patient has a right to considerate and respectful care.

2. The patient has the right to receive his/her therapist(s) complete and current information concerning the diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand.

3. The patient has the right to receive from his/her therapist(s) information necessary to give informed consent prior to the start of any procedure and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action.

5. The patient has the right to every consideration of his/her privacy concerning his/her own medical care program.

6. The patient has the right to expect that all communication and record pertaining to his/her care will be treated as confidential

7. The patient has the right to expect that within its capacity, the clinic will make reasonable effort to respond to the request/need of a patient for service.

8. The patient has the right to obtain information as to any relationship of the clinic to other health care and educational institutions as far as his/her care is concerned.

9. The patient has the right to expect reasonable continuity of care.

10. The patient has the right to examine and receive an explanation of his/her bill regardless of source of payment.

11. The patient has the right to be informed of charges or services not covered by Medicare or any federally funded program.

12. The patient has the right to have his/her spiritual, religious and cultural needs recognized.

13. The patient has the right to know what clinic rules and regulations apply to his/her conduct as a patient.

14. The patient is responsible for following clinic guidelines affecting patient care and the right of the other patients.

15. The patient is responsible for interacting with clinic staff in a considerate and respectful manner.

16. The patient is responsible for following the treatment plan recommended by the physician(s), therapist(s) responsible for his/her care.

17. The patient has the right to be informed of any human experimentation or other research or educational projects affecting his/her care.

18. The patient has the right to file a grievance with the Administrator if he/she feels his/her right have been violated in any way.

If Patient is under 18 Parent or Guardian Must Sign for Patient

Signature _____ Date _____

Parent or Guardian Signature _____

Parent or Guardian Printed Name _____ Relationship to Patient _____

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Consent to Treat

Payment Policy & Billing Procedures

1. Unless 100% coverage has been verified, you are responsible for the percentage &/or deductible not covered by your insurance company. This payment is requested during each visit.

2. If insurance information is not available or you do not have insurance, payment is due in full unless other arrangements have been approved by our Centralized Billing Office (CBO).

3. You will receive a monthly statement which will show you the status of your account.

4. We accept VISA, MasterCard, and Discover bankcards.

5. There is a $25 charge for all returned checks.

Insurance Information

As a courtesy to our patients, we will verify and file your insurance; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many Insurance companies have stipulations, such as usual & customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED by your insurance. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

Worker's Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Knob Noster Physical Therapy. Knob Noster PT has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policy & billing procedures of Knob Noster Physical Therapy. I hereby authorize Knob Noster PT to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign Knob Noster PT all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Knob Noster Physical Therapy. It is understood that any money received from the above-named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Knob Noster PT for charges not covered by my insurance company. I certify by my signature.

If Patient is under 18 Parent or Guardian Must Sign for Patient

Signature _____ Date _____

Parent or Guardian Signature _____

Parent or Guardian Printed Name _____ Relationship to Patient _____

Witness _____ Date _____

Knob Noster
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Patient Privacy Form

Use & Disclosure of Your Protected Health Information

Your protected health information will be used by Knob Noster Physical Therapy or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice as described in detail on the previous page.

Notice of Privacy Practices

You should review this document for the complete description of how your protected health information may be used or disclosed.

Requesting a Restriction on the Use of Disclosure of your Information

You may submit a request in writing as outlined above to restrict your information, however, Knob Noster Physical Therapy may or may not agree to restrict the use or disclosure of your protected health information. If Knob Noster Physical Therapy agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Knob Noster Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE: I have reviewed this document and give my permission to Knob Noster Physical Therapy to use and disclose my health information in accordance with it.

If Patient is under 18 Parent or Guardian Must Sign for Patient

Signature _____ Date _____

Parent or Guardian Signature _____

Parent or Guardian Printed Name _____ Relationship to Patient _____

Knob Noster
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Medical History Form

Patient Name: _____ Height: _____ Weight: _____

What are we seeing you for? _____

Date of injury: _____ How did injury occur? _____

Have you been hospitalized for this condition? □ Yes □ No If Yes, date(s): _____

Have you had surgery for present condition? □ Yes □ No If Yes, date: _____

If yes, surgery type: _____

Have you received any previous treatment for this condition? □ Yes □ No If Yes, date(s): _____

If yes, please summarize: _____

Have you had any of the following? □ MRI □ X-ray □ CT Scan □ Other: _____

Due to injury is there anything you can't do right now (hobbies, sports, work)? _____

Please mark if you have, or have had, any of the following **conditions** and if you are currently taking **medication** for that condition?

	Yes	Rx		Yes	Rx
Allergies, if so to what:			Heart Attack		
Anxiety or Panic Disorders			Hepatitis A, B, C		
Asthma			HIV/AIDS		
Bleeding Disorder			Hyperlipidemia (High Cholesterol)		
Bowel or Bladder issues			Hypertension (High Blood Pressure)		
Cancer, if so what kind:			Multiple Sclerosis		
Chronic Obstructive Pulmonary Dis. (COPD)			Night Pain or Night Sweats		
Congestive Heart Failure (CHF)			Osteoarthritis		
Cardiovascular Disease (CVD)			Osteoporosis		
Degenerative Disc Disease			Parkinson's Disease		
Depression			Peripheral Vascular Disease		
Diabetes			Rheumatoid Arthritis		
Emphysema			Stroke or TIA		
Epilepsy or Seizure Disorder			Unexpected Weight Loss		
Fibromyalgia			Vestibular Issues or Dizziness		
Headaches/Migraines			Other:		

Are you currently pregnant? □ Yes □ No Pacemaker/Defibrillator? □ Yes □ No Do you Smoke? □ Yes □ No

Surgical History (unless list has been provided): _____

Have you had any falls in the past year? □ Yes □ No If Yes, did you have any injuries? _____

To help us understand your symptoms please circle what applies to your symptoms:

My pain is **worse** with: in the morning/ during the day/ at night/ constant/ with activity/ during rest

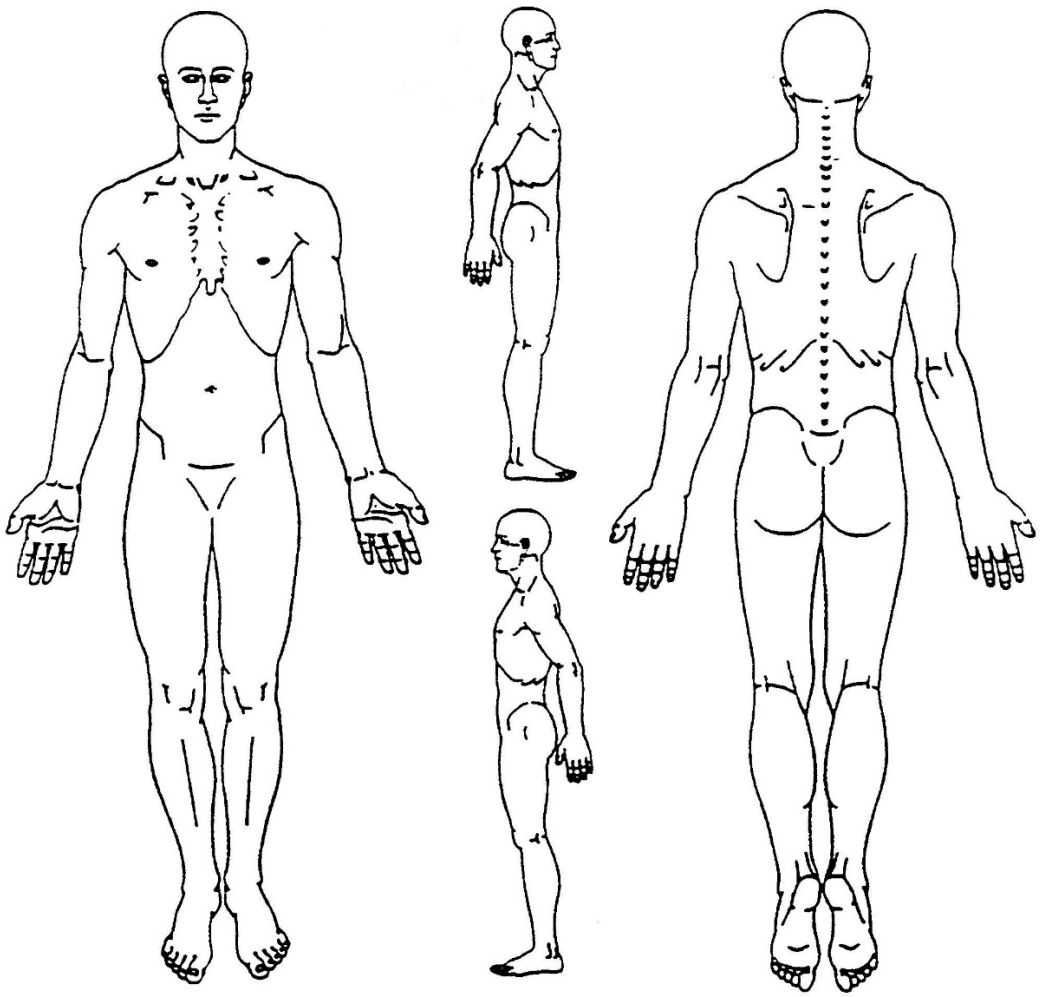
On a scale of 0 to 10 (0 being no pain and 10 being the worst pain imaginable), please rate your pain:

Currently _____ At Worst _____ At Best _____

Describe your pain (throb, ache, sharp, numbness, tingling, shooting, stabbing): _____

Please use the following key to fill out the pain/symptom diagram below:

↑ or ↓ Radiating Pain //// Numbness/Tingling XXX Spasm 000 Ache/Pain ZZZ Tenderness



What would you like to accomplish in physical therapy? _____

How did you hear about Knob Noster Physical Therapy? □ Physician □ Friend/Family □ Print Ad □ Online
□ Other: _____
