



**NEW PATIENT INTAKE FORM**

**Date:** \_\_\_\_\_

<u>Last Name:</u>	<u>First Name:</u>
Date of Birth:	Gender: <b>Male</b> <b>Female</b>
Social Security Number: ____ - ____ - ____	Email: _____
Address: _____ Apt # _____ City: _____ State: _____ Zip: _____	Home Phone: (____) _____ Cell Phone: (____) _____

**Emergency Contact**

Name:	Relationship:	Phone: (____) _____
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**Employer Information**

Employer:	Address:	Phone: (____) _____
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**Insurance**

<b>Primary Insurance</b>	
Name of Insurance:	ID Number:
Policyholder's Relation:	Policyholder's Date of Birth:
<b>Secondary Insurance</b>	
Name of Insurance:	ID Number:
Policyholder's Relation:	Policyholder's Date of Birth:

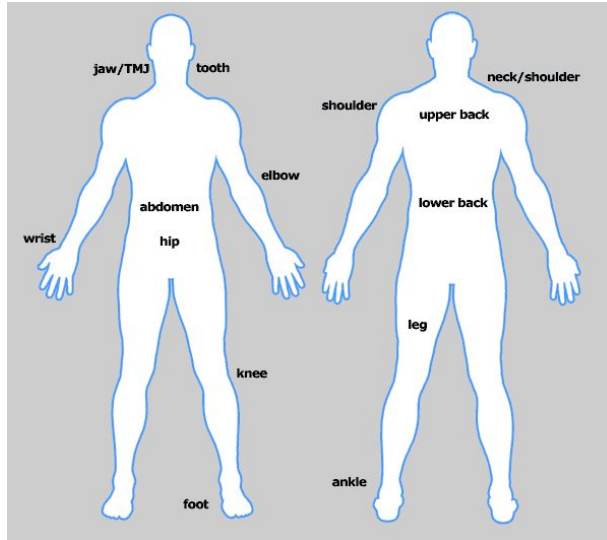
**Responsible Party Information (Parent/Guardian must complete if patient is under 18)**

Name:	Relationship:	Phone: (____) _____
Date of Birth:	Address:	

**Problem/Condition**

Description of Problem:	Primary Care Doctor:
Date of Onset/Injury:	Surgeon and Date of Surgery:
Referred By:	

Please mark on the drawing below where you feel pain.



Is this injury/illness due to any of the following: Circle: Work    Auto    Accident    Other    N/A

Have you ever been treated at Golden Hills Physical Therapy? Circle: Yes    or    No.

If yes, when: \_\_\_\_\_.

Have you had physical therapy, occupational therapy or chiropractic treatment this year for this condition? Circle: Yes    or    No. If yes, please indicate the type of treatment and the duration of

treatment: \_\_\_\_\_.

How did you hear about us? Circle: Physician    Family/Friends    Social Media    Other: \_\_\_\_\_

**Accident Injuries ONLY:**

Name of Insurance: _____	Adjuster: _____	Attorney: _____
Claim Number: _____	Phone: (____) _____	Phone: (____) _____
Date of Accident: _____	Fax: (____) _____	Fax: (____) _____
State of Accident: _____	E-Mail: _____	E-Mail: _____
Additional Details: _____		

**Medicare Patients ONLY:**

When did you last receive HOME HEALTH CARE, HOSPICE CARE or care in a SKILLED NURSING FACILITY? \_\_\_\_\_

If yes, please provide the name and phone number of the Home Health Agency:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**CONSENT TO TREAT:** I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:**

I certify that all the information I have provided is accurate and I understand that providing misinformation will result in the delay of my claims being processed and or result in me being liable to GHPT for all my visits. I understand that I am financially responsible for my medical bills incurred while receiving Physical Therapy Services at Golden Hills PT (GHPT). I agree to pay GHPT all amounts that are due and owing for services rendered by our facility which are not otherwise paid for by Medicare, a third party insurance plan, a third party payer, or other payer source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by our facility including, without limitation, reasonable attorney's fees. I also understand that GHPT will submit my insurance claims as a courtesy to me, but this does not relieve from my financial responsibility to GHPT. I hereby authorize payment of medical benefits directly to GHPT for services rendered. I further authorize the release of any medical information necessary to process any insurance claim on my behalf. I permit a copy of this authorization to be as valid as the original. Where applicable I authorize filing a Lien against any and all third party liability action relating to the need for treatment including the worker compensation cases. I also understand that I am financially responsible for any and all non-covered charges, deductible and co-pays. I also agree that if for any reason my insurance does not cover physical therapy services I will pay for all charges. By signing below I authorize GHPT to treat the above name patient. I acknowledge that I have read and understand all of the above terms. I authorize GHPT to assign their rights under this contract to a third party. **COPAYMENT IS DUE AT THE TIME OF SERVICE.**

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:**

I understand that, under the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice or Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice or Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain current copy of the Notice or Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**CANCELLATION/ NO SHOW POLICY:**

**Late Arrival Policy:** If you are late for an appointment, you will be seen as soon as we can possibly accommodate you, and for the length of time remaining to your appointment. If you are over 20 minutes late to your appointment, you may have to be rescheduled and you will be charged a \$25 fee. **Initial** \_\_\_\_\_

**Cancellation Policy:** If you need to cancel an appointment, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given, you will be charged a \$25 cancellation fee. **Initial** \_\_\_\_\_

**No Show Policy:** If you do not show up for a scheduled appointment, you will be charged a \$50 no show fee. **Initial** \_\_\_\_\_

Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients. Missed appointments prevent other patients from coming in at the same time and affect the consistency of your own rehabilitation program. As a result, 3 late cancellations or no shows will result in discontinuing physical therapy at Golden Hills Physical Therapy. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy. I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHOTOGRAPHY CONSENT FORM / RELEASE:**

I, (print name) \_\_\_\_\_, hereby grant permission to Golden Hills Physical Therapy representatives, to take and use: photographs, video, and/or digital images of me for use in news releases and/or educational materials.

If patient is a minor (under age of 18): I, (print name) \_\_\_\_\_, parent or official guardian of (child's name) \_\_\_\_\_ hereby grant permission to Golden Hills Physical Therapy representatives, to take and use: photographs, video, and/or digital images of my child for use in news releases and/or educational materials.

These materials may include printed or electronic publications, Web sites or other electronic communications. I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Golden Hills Physical Therapy.

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## FOTO Patient Intake Survey

### Neck, Cranium / Mandible, Thoracic Spine, Ribs

*Staff to Complete*

PATIENT NAME: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Gender: Male / Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Clinician: \_\_\_\_\_

Body Part \_\_\_\_\_ Impairment \_\_\_\_\_ Care Type \_\_\_\_\_

Payer Source \_\_\_\_\_ *(Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)*

Date of Survey: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, does or would your health problem limit:	Yes, limited a lot	Yes, limited a little	No, not limited at all
1. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?			
2. Participating in recreation?			
3. Moderate activities like moving a table or pushing a vacuum cleaner, bowling, or playing golf?			
4. Lifting or carrying items like groceries?			
5. Lifting overhead to a cabinet?			
6. Gripping or opening a can?			
7. Handling small items like pens or coins?			
8. Feeding yourself?			
9. Getting in and out of bed?			
10. Bathing or dressing?			
11. Completing your toileting?			

12. Rate the level of pain you have had in the last 24 hours *(please circle response)*:

0    1    2    3    4    5    6    7    8    9    10  
 (None) (Pain as bad as it can be)

13. Please indicate the number of surgeries for your primary condition.     None     1     2     3     4+
14. How many days ago did the condition begin?     0-7 days     8-14     15-21     22-90     91 days to 6 mos. ago     Over 6 mos. ago
15. Are you taking prescription medication for this condition?     Yes     No
16. Have you received treatments for this condition before?     Yes     No

17. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

At least 3 times a week     
  Once or twice per week     
  Seldom or never

18. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis)   | <input type="checkbox"/> Visual impairment (such as cataracts, glaucoma, macular degeneration)            |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids)                |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems                                 |
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Previous accidents   |
| <input type="checkbox"/> Congestive heart failure (or heart disease)   | <input type="checkbox"/> Allergies  |
| <input type="checkbox"/> Heart attack (Myocardial infarction)  | <input type="checkbox"/> Incontinence   |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Anxiety or Panic Disorders   |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's)  | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Stroke or TIA   | <input type="checkbox"/> Other disorders  |
| <input type="checkbox"/> Peripheral Vascular Disease   | <input type="checkbox"/> Hepatitis / AIDS   |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Prior surgery  |
| <input type="checkbox"/> Diabetes Types I and II   | <input type="checkbox"/> Prosthesis / Implants  |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)                              | <input type="checkbox"/> Sleep dysfunction  |
|  | <input type="checkbox"/> Cancer   |

19. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.      Weight: \_\_\_\_\_ lbs.

20. This is a statement other patients have made.

***"I should not do physical activities which (might) make my pain worse."***

Please rate your level of agreement with this statement.

- Completely Disagree  
 Somewhat Disagree  
 Unsure  
 Somewhat Agree  
 Completely Agree

# NECK DISABILITY INDEX

Instructions: this questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider two of the statements in any section may relate to you, but please mark the box which most closely describes your problem TODAY.

## 1. PAIN INTENSITY

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

## 2. PERSONAL CARE

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most of my personal care
- I don't get dressed, I was with difficulty and stay in bed

## 3. LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

## 4. READING

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

## 5. HEADACHES

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have headaches almost all the time

## 6. CONCENTRATION

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want
- I cannot concentrate at all

## 7. WORK

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

## 8. DRIVING

- I can drive without any neck pain
- I can drive my car as long as I want with only slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I can't drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all because of severe pain in my neck

## 9. SLEEPING

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-5 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

## 10. RECREATION

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of my neck pain
- I am able to engage in only a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all because of pain in my neck