Patient Intake Form

Flicker Physical Therapy

Date: _______________ Gender: M F Age: _______

Patient Full Name: ___________________________________

Preferred Name: ______________________ Social Sec #: _______________________

Date of Birth: ___/____/_____ Marital Status: Single Married Divorced Widowed

Preferred Phone #: **Cell Home** ________________ Alt. Phone #: ________________

Address: ____

City, State, Zip: ____

Email: __________________________________Occupation: ______________________

(used only for sending appointment reminders and Home Exercise Programs)

Physician referring you for therapy: ____

Primary care physician: ____

Emerg. Contact Name and #: _________________________ Relationship: _________

What is your preferred method of communication? **Phone call** **Text** **Email**

Would you like appointment reminders? **Phone call** **Text** **Email** **No reminders**

**Patient is responsible for keeping appointments; missed appointments will be charged $25 fee if 24-hour notice not given.*

Patient Agreement and Responsibilities

Please initial next to each item.

______ I understand that successful therapy treatment includes all of the following:

- **Consistent attendance at my therapy appointments.**
- **Performing home exercises as prescribed by my providers.**
- **Modifying activities that I am asked to alter in order to effectively meet goals.**

_____ I have read the financial policy of Flicker Physical Therapy LLC (see next page). I understand that I am responsible for knowing my insurance coverage and benefits. Any portion of the bill not paid by insurance will be my responsibility. *Please mark here if you would like to speak further with the office staff about billing or insurance questions:* ☐ *Yes, I still have billing, cost, or insurance questions.*

Authorization of Release of Information

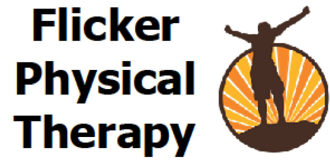
I have been given notice of the Privacy Practices of Flicker Physical Therapy LLC and may request a copy at any time.

I authorize the release of any information acquired in the course of my treatment to my insurance carrier and physician. I authorize payment of medical benefits directly to Flicker Physical Therapy LLC for services rendered. I accept full responsibility for payment of services not covered by my insurance. I understand that if my account is not paid in full, I am subject to be charged for any additional fees incurred by Flicker Physical Therapy LLC to collect my balance.

X_________________________________ ______/______/______

Patient/Guarantor Signature **Date**

Patient Financial Agreement



Insurance claims: Flicker Physical Therapy will bill insurance as a courtesy. It is the patient's responsibility to know the coverage and benefits for therapy. Any insurance balance that is unresolved will become the patient's responsibility.

Co-Pays: Patient agrees to pay any co-payments, co-insurance, and deductible amounts at the time of service. If you do not know your co-payment or if your insurance coverage is partial, patient will be responsible for a charge of $25.00 at the time of service.

Credit/Collections: If unable to pay bill in full, patient should request extended credit through the office. If approved for monthly payments, the minimum payment will be $25 or 5% of your account balance, whichever is greater. If collection becomes necessary, patient is responsible for collection costs.

Cancellations/Missed Visits: Flicker Physical Therapy reserves the right to charge $25 for each visit that is not cancelled with at least 24 hours' notice. Cancellations or missed appointments can be reported to your physician and may result in discharge from physical therapy.

Please Note: The staff at Flicker Physical Therapy cares about your health and overall well-being. When a patient does not attend an appointment as scheduled, this not only affects the patient, because he or she does not receive the treatment needed, but it also affects the therapist, who reserved a space in their schedule, and other patients, who could have been treated during the reserved time had proper notice been given.

Worker's Compensation: If your physical therapy is being paid through your employer's Worker's Compensation, you are required to follow the physician's orders for physical therapy. If you are not compliant with these orders, your claim might be denied and you will be held responsible for the bill.

Auto Insurance Claims: If you request Flicker Physical Therapy to bill a third-party auto insurance due to a motor vehicle collision you are required to make a $25 co-payment per visit and sign a medical lien form guaranteeing Flicker Physical Therapy payment for services at the time of your settlement. If a settlement is not reached within 30 days of completion of treatment, you will be responsible for the entire bill. We will be happy to provide you with the information required for you to get reimbursement from the insurance carrier.

I have read and agree to abide by the Flicker Physical Therapy Financial Policy.

X_________________________________ ______/______/______

Patient/Guarantor Signature **Date**

Insurance Information: *Please provide all insurance cards to office staff for review.*

Primary Insurance: ____________________________ ID or Claim#: ________________________________

Subscriber's Name and Date of Birth (if different than patient): _____________________________________

Secondary Insurance: __________________________ ID#: _______________________________________

Subscriber's Name and Date of Birth (if different than patient): _____________________________________

For Worker's Compensation Claims: WC Insurance Company: _____________________________________

Date of Injury: ______________ Claim #: ____

Adjustor name and phone: ____

Employer Name, Address, Phone: ____

Flicker Physical Therapy

Patient Name: ____________________ Today's Date: _______________

Description of Physical Therapy Need

1. Reason for Physical Therapy: (include area of body, symptoms, cause, etc.)

____

____

2. Treatment side (Right/Left): _____________________________________
3. Date the symptoms started or injury occurred: ______________________
4. Date of surgery for this condition (if applicable): ___________________
5. What are your goals for physical therapy?

____

____

____

6. What was your prior level of function?
   No Impairment   Mild Impairment   Moderate Impairment   Extreme Impairment
7. What is your current level of function?
   No Impairment   Mild Impairment   Moderate Impairment   Extreme Impairment
8. Please rate the level of pain related to your complaint:

0=None   5=Moderate   10=Extreme

Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

9. What seems to make the symptoms worse? ___________________________

____

10. What seems to relieve the symptoms? ______________________________

____

11. List history of falls (including dates) related to this condition or any other condition:

____

____

Patient Name: ____________________ Today's Date: _______________

Medical History

Current Age: ___________

Patient Height: ______ feet, _______ inches **Patient Weight:** _____________ lbs.

Have you recently noted any of the following (check all that apply)?

- ☐ Changes in bowel/bladder function
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance while walking
- ☐ Weight loss/gain
- ☐ Shortness of breath
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Fever/chills/sweats
- ☐ Increased pain at night
- ☐ Weakness/fatigue
- ☐ Difficulty in swallowing

Have you ever experienced any of the following?

- ☐ Cancer: __________
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Chemical Dependency
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Depression
- ☐ Anemia
- ☐ Lung Problems
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Stomach ulcers
- ☐ Epilepsy
- ☐ Parkinson's Disease
- ☐ Other: _______________
- ☐ Other: _______________

Other surgeries or hospitalizations, including approximate dates:

____

____

Current Medications (we can make a photocopy if you have a list):

____

____

Other conditions or concerns about which you would like the therapists to know:

____

____