Active Life & Sports

Patient Information Form
Please Print

Patient Name:_____ E-mail:_____

Address/City/State: _____Zip_____

Phone: _____ Sex: _____ Marital Status_____

Date of Birth: _____ Patient's Social Security #:_____

Employer: _____ Employer Phone: _____

INSURANCE #1:_____

Insured Name: _____Relationship to Patient:_____

Date of Birth: _____ Policy is Through: _____
(Employer or Self)

INSURANCE #2:_____

Insured Name : _____Relationship to Patient_____

Date of Birth_____ Policy is Through: _____
(Employer or Self)

Referring Physician Name: _____

Primary Care Physician Name: _____

Emergency Contact Name**:** _____Phone:_____

Relationship to Patient**:** _____

INJURY/DIAGNOSIS: _____

Are your injuries the result of an auto accident? Yes or No If yes, when did the accident occur? Date_____ What state did the accident occur?_____

Are your injuries work related? Yes or No If yes, when did your injuries occur? _____

If not auto or work related when did your injury/surgery occur? _____

I agree to receive or give permission for myself, or the above-named minor, to receive Physical Therapy services appropriate for this condition. I authorize the release of any information necessary for care and to process insurance claims. I authorize direct payments to be made to **Active Life & Sports Physical Therapy** for physical therapy services and I understand that I am responsible for any amount not covered by my insurance company. I have read and understand the Active Life & Sports Physical Therapy privacy policy.

SIGNATURE_____DATE_____

Active Life & Sports PT
Michael D. Wah, PT, OCS
4337 Ebenezer Road
Nottingham, MD 21236
Phone 410-529-3303
Fax 410-529-7980

Active Life & Sports PT Intake Form

Name:			Date of Birth:	Age:
Gender: M ☐ F ☐	Height:	Wt:	Occupation:	
What is your usual activity/exercise routine?			# Days/week:	minutes/day:
When was the last time you saw your primary care doctor?				

Past and Current Medical Conditions

In the section below, please check the box and <u>circle</u> any disorders that you currently have or that you've had in the past.

☐	**Neurological -** MS, stroke or TIA, spinal cord injury, neuropathy, dementia/Alzheimer's, seizures	☐	**Hormonal -** Diabetes**;** If yes, how long? _____ ; Recent A1C _____ . Thyroid disorder, osteoporosis
☐	**Heart and Circulation -** High/low blood pressure, heart attack/angina, poor circulation, high cholesterol, arrhythmia, congestive heart failure., syncope, drop attack	☐	**Genital and Urinary -** Prostate, gynecological conditions. Urinary retention, frequency, loss of control of bowel or bladder, impotence
☐	**Digestive -** Hepatitis/Cirrhosis, irritable bowel, reflux, ulcer/G.I. bleeding, kidney disease., heartburn or indigestion, food intolerances	☐	**Blood -** Anemia, sickle cell disease, blood clot, Immune suppression HIV/AIDS, bleeding disorder
☐	**Breathing -** COPD/emphysema, tuberculosis, asthma, sleep apnea	☐	**Cancer** (please describe, including surgeries)
☐	**Substance usage -** caffeine, alcohol, tobacco, recreational drugs	☐	**Arthritis -** Lupus, rheumatoid arthritis, osteoarthritis
☐	**Surgical history(use a separate sheet if Necessary)** ☐ Implanted Electronic Device	☐	**Other Surgeries or Conditions:**

Current Health

In the past three months, have you had or do you experience:			
☐	Fatigue or Malaise	☐	Numbness, Tingling or genital area numbness
☐	Fever/Chills/Sweats/Infection	☐	Bowel or Bladder Problems
☐	Nausea and/or vomiting	☐	Problems with cognition/thinking
☐	Swelling in your arms or legs	☐	Dizziness/Lightheadedness
☐	Unexplained weight change	☐	Reduction in balance, coordination and/or walking
☐	Extremity weakness	☐	Loss of consciousness, syncope, drop attacks
☐	Shortness of breath or difficulty breathing	☐	Difficulty swallowing or speaking
☐	Change of appetite	☐	Frequent coughing
☐	Chest pain/ Irregular heart rate/Palpitations	☐	Falls – How many in the past year?

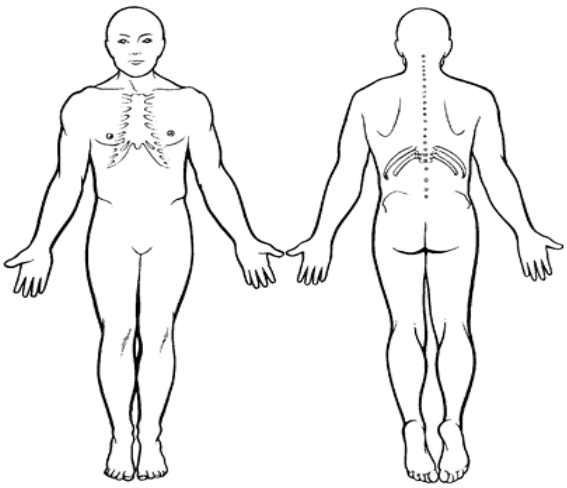
Do you have difficulty hearing in noisy environments, such as a restaurant or party?	☐ Yes ☐ No
Do family members or friends think you have difficulty hearing?	☐ Yes ☐ No
During the past month have you often been bothered by feeling down, depressed or hopeless?	☐ Yes ☐ No
During the past month have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No
Is this something with which you would like help? ☐ Yes, today ☐ Yes, but not today	☐ No

What other providers do you treat with? ☐ Chiropractor ☐ ENT ☐ Orthopedist ☐ Neurosurgeon ☐ Psychologist/Psychiatrist ☐ Pain Management ☐ Other

Please list your medications, with dosages:

Do you take blood thinners?	☐ Yes ☐ No
Have you ever taken steroids for an extended period of time (more than three months)?	☐ Yes ☐ No

Pain Diagram



Please mark on the chart above, the areas where you feel pain.

Please list any <u>diagnostic tests</u> regarding your current problem (MRI, X-ray, VNG/ENG etc.)

What is your primary reason for coming to PT?

What date (approx) did your symptoms start?

What do you think caused your symptoms?

Are your symptoms: (check one)
____ worsening, ____ staying the same, ____ improving

Patient Signature _____

Date _____

Symptom <u>Average</u> for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Imaginable Pain

<u>Worst</u> for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Imaginable Pain

<u>Best</u> for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Imaginable Pain

Therapist Use

Functional Instrument _____ Vitals HR _____ BP _____ SpO2 _____%

Score _____

Functional Instrument _____

Score _____

Screening Tests/Questions or referral required:

Neurological Cardiovascular Respiratory
Muscskel Fx Blood disorders G.I.
Urinary/Genital Arthritis Endocrine
Mood

Reviewing Therapist _____ Date _____

Active Life & Sports
THERAPY FIT FOR YOU

PAYMENT POLICY AND PROCEDURES

*********There will be a $20.00 charge for any returned checks*******

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance claim; 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 and customary fees (UCR), limited therapy sessions, limit reimbursable amounts per session, deductibles, co-payments, limits on 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.

Workers 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 **Active Life and Sports Physical Therapy. Active Life and Sports Physical Therapy** 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 alternative treatment plan that has been prescribed by my physician and or recommended by my therapist. By signing this agreement, I consent to have **Active Life and Sports Physical Therapy** provide treatment and care as prescribed by my physician and/or recommended by my therapist.

ASSIGNMENT OF PAYMENT

I understand, fully, the payment and billing procedures of **Active Life and Sports Physical Therapy**. I hereby authorize **Active Life and Sports Physical Therapy** to furnish my insurance company(s), attorney, or legal representative all information that said parties may request concerning my present illness or injury. **I hereby assign Active Life and Sports Physical Therapy all money to which I am entitled for medical expenses related to the services reported here,** but not to exceed my indebtedness to **Active Life and Sports Physical Therapy**. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to **Active Life and Sports Physical Therapy** for charges not covered by my insurance company. **I agree to pay interest at the rate of 1.5% per month on any unpaid balance owed on my account, and further agree to pay attorney fees equal to 30% of the total amount due, should my account be referred to an attorney for collection**. I certify by my signature that I have read and agree to this information.

Please mail all payments to: **ACTIVE LIFE AND SPORTS PHYSICAL THERAPY**
4337 Ebenezer Road
Perry Hall, Maryland 21236

Signature: _____ **Date:** _____
Printed Name: _____ **Relationship to patient:** _____

Active Life & Sports PT **4337 Ebenezer Road** **Phone (410)529-3303**
Michael D. Wah, PT, OCS **Perry Hall, MD 21236** **Fax (410)529-7980**

CANCELLATION/NO SHOW POLICY AGREEMENT

PATIENT NAME: _____ DATE: _____

It is our desire at **Active Life and Sports Physical Therapy** to provide each patient with the highest quality of services in the most expeditious manner. Therefore, we provide a reserved time slot for each patient so that there is minimal waiting and each person receives individual attention.

In order for us to continue with this service, we ask that you **call at least 24 hours in advance** if you are unable to keep your scheduled appointment. Missed appointments without notification will result in a **$40.00** no show charge. **Furthermore, additional visits that you have scheduled will be automatically canceled.**

Additionally, three (3) missed appointments during the course of your treatment will require us to discharge you from physical therapy and inform your physician, case manager, and/or insurance carrier of our discharge status. We understand that personal schedules can be hectic, but in order to accommodate the needs of all our patients, we must maintain some level of accountability. As well, missed appointments on your part do not allow for continuity of care and affects your ability to reach the goals as outlined by you and your physical therapist.

We appreciate the opportunity to provide your rehabilitation care. Thank you for your consideration of our staff and other patients who may need your appointment time.

I have reviewed and agree to comply with the above cancellation policy.

_____ _____

Signature Date

HIPAA PRIVACY AUTHORIZATION

I, _____, give Active Life & Sports permission to share information with:

□ Any member of my family

□ These individuals: _____

□ Do not speak with my family or friends about my healthcare unless I give you specific permission at a later time.

This information may be sent to health care providers or health insurance companies protected by the federal privacy regulations, but also to the individual/s of your choice.

Your information may be:

Transferred or utilized between the administrative and professional staff.

Transferred from Active Life & Sports to the billing contractor who handles our billing, has signed an agreement not to utilize your records other than those necessary to administer your insurance claim and pervade internal reports to Active Life & Sports.

You may refuse to sign this authorization and it will not affect your ability to obtain treatment. You may receive a copy of this authorization at the time of signing and/or revoke this authorization at any time by sending a written notification to the office.

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

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