

Welcome! to Summit Physical Therapy, Inc.

(PLEASE PRINT)

NAME _____ TODAY'S DATE _____
Last First MI

ADDRESS _____ APT# _____ HOME PH# _____
Preferred ☐

CITY _____ ST _____ ZIP _____ CELL PH# _____
Preferred ☐

SEX ☐ M ☐ F AGE _____ BIRTHDATE ____/____/____ EMAIL: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

HOW DO YOU WANT TO RECEIVE APPOINTMENT REMINDERS? ☐ TEXT ☐ EMAIL ☐ AUTOMATED CALL ☐ NONE

EMERGENCY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT'S BEST PHONE NUMBER _____

IS THE PATIENT A MINOR? ☐ NO ☐ YES IF SO, RESPONSIBLE PARTY _____

RESPONSIBLE PARTY BIRTHDATE ____/____/____ RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE CO _____ **PLEASE PROVIDE CARD TO BE COPIED**

SUBSCRIBER (IF OTHER THAN YOU) NAME _____ DOB ____/____/____

SECONDARY INSURANCE CO _____ **PLEASE PROVIDE CARD TO BE COPIED**

SUBSCRIBER (IF OTHER THAN YOU) NAME _____ DOB ____/____/____

DOES YOUR TREATMENT NEED RELATE TO AN INJURY BEING COVERED BY AN OPEN WORK COMP CLAIM? ☐ NO ☐ YES
DOES YOUR TREATMENT NEED RELATE TO AN INJURY BEING COVERED BY AN OPEN AUTO ACCIDENT CLAIM? ☐ NO ☐ YES

IF YES TO EITHER, DATE OF INJURY ____/____/____ INSURANCE CO _____

CLAIM# _____ ADJUSTER NAME _____

ADJUSTER PH# _____ ADJUSTER FAX# _____

How did you hear about us?

☐ RECOMMENDED BY DR. _____ ☐ REFERRED BY FRIEND/FAMILY ☐ I AM A FORMER PATIENT

☐ NETWORK PROVIDER LIST ☐ WEBSITE/ONLINE SEARCH ☐ WORD OF MOUTH ☐ SIGN/DROVE BY

ASSIGNMENT & RELEASE OF BENEFITS:

I hereby assign all benefits from the above-named insurance(s) to be paid directly to Summit Physical Therapy for services rendered. I authorize the use of my signature on all insurance submissions. Summit Physical Therapy may use my healthcare information and may disclose such information to the above-named insurance company(ies) for the purpose of obtaining payment and for determining insurance benefits or the benefits payable for related services.

SIGNATURE

PRINTED NAME

(FOR OFFICE USE ONLY) VERIFICATION OF DEMOGRAPHICS/NO CHANGE: (FOR FUTURE VISITS)

DATE _____ INITIALS _____ / DATE _____ INITIALS _____ / DATE _____ INITIALS _____

SUMMIT PHYSICAL THERAPY

Policies & Procedures

Please initial beside each section, and sign and date below.

_____ Cancellations:

Three people are affected when you miss an appointment without notice. You don't get treated, another patient misses an opportunity to be seen, and the therapist has a gap in his schedule. Our 24-hour voicemail can take your cancellation call at any time, even when the office is closed. **Please give us a timely notice, preferably 24 hours in advance. Short cancellations and no-shows will incur a \$35.00 charge.**

_____ Co-pays & Deductible:

Insurance co-pays are due at the time of service. If you have an insurance deductible due, you will be asked to pay a minimum of \$50.00 towards that amount at the time of service. Any additional balance will be billed to you after the insurance has completed their processing. We have a returned-check fee of \$25.00.

_____ Financial Responsibility:

We bill your insurance as a courtesy, and will work with the insurance to resolve any denied claims or problems. **However, ultimate responsibility for payment of services rests with the patient.** We are always happy to work with you on payment plans during times of financial hardship, but accounts that become past due without any effort towards payment will be assigned to an outside collection agency, which may adversely affect your credit rating.

_____ Privacy:

Summit Physical Therapy is committed to maintaining your privacy and protecting your personal health information. Your signature below indicates your acknowledgement that you have received a copy of our Patient Privacy Policy.

_____ Release of Information:

Your signature below authorizes us to exchange any information necessary for your treatment with other medical providers involved in your care, including but not limited to history obtained, x-ray and physical findings, diagnosis and prognosis, and record of current treatment plan.

Signature

Date

Printed Name

Relationship to patient (if other than self)



PATIENT INTAKE FORM

Name _____ Date _____

Height _____ Weight _____ Age _____ Occupation _____

Referring Physician _____

1. Please describe in detail the condition we are seeing you for:

2. Do you know what originally caused this condition/issue? Yes No If yes, please explain:

3. Date of onset: _____ Surgery Date (if applicable): _____

4. Do you have (circle all that apply): pain numbness tingling stiffness weakness swelling

5. Are your symptoms (circle one): continuous intermittent related to specific activities

6. Overall, are your symptoms (circle one): getting better staying the same getting worse

7. Please mark on the line to indicate how severe your pain was:

At its worst (write "W") and as it is today (write "T")

NO PAIN [0 ----- 5 ----- 10] PAIN AS BAD AS IT CAN GET

8. Do symptoms awaken you at night? (circle one) yes no

9. What time of day is it worse? _____

10. What makes your symptoms worse? _____

11. What makes your symptoms better? _____

12. What previous tests/studies have been done for this condition? (MRI, x-ray, etc)

13. Please circle any of the following you have seen recently:

Medical Doctor Osteopathic Specialist Podiatrist Chiropractor Physical Therapist

Other: _____

14. Please list any other diagnosed medical problems: (heart disease, cancer, diabetes, hepatitis, etc)

15. Please list all previous injuries and surgeries with approximate dates:

16. Please list all medications you are currently taking (prescription and non-prescription):

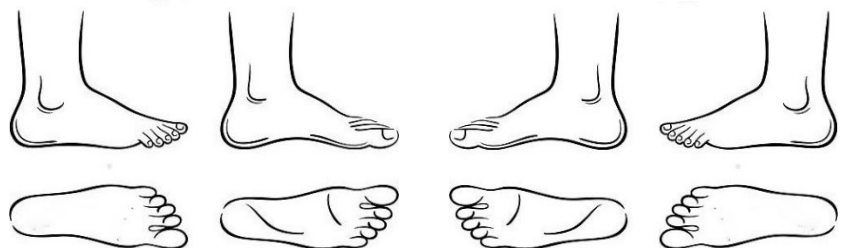
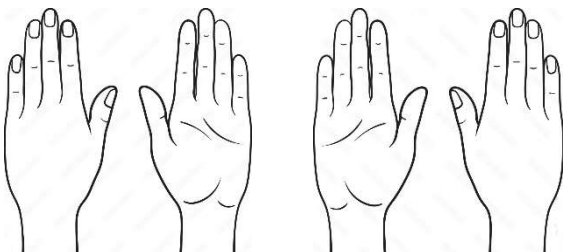
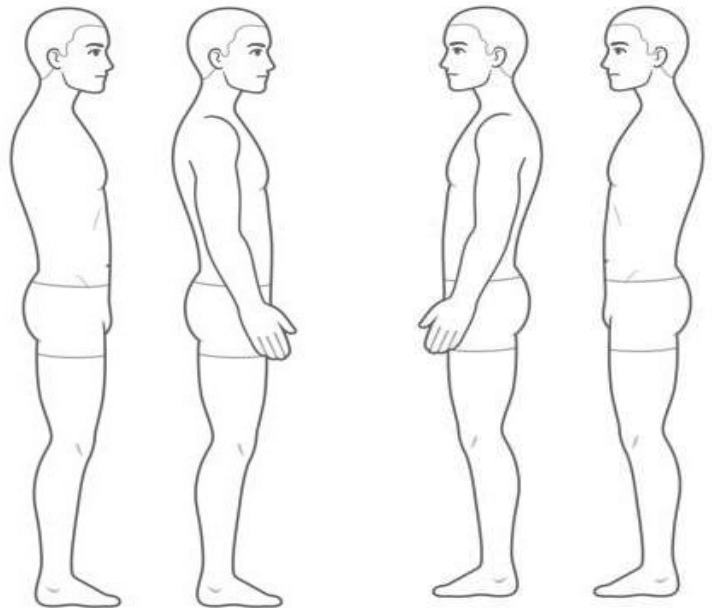
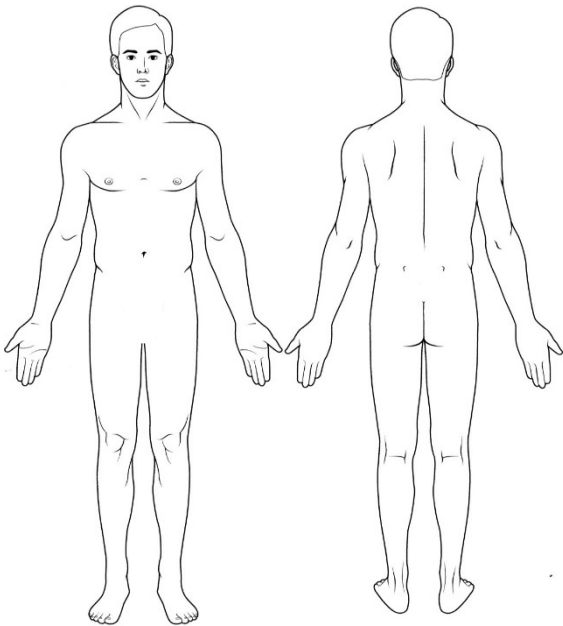
17. When is your next doctor's appointment? _____

18. How is your general health? (circle one) Excellent Good Fair Poor

19. Are you currently exercising? (circle one) Yes No If yes, please describe: _____

20. What are your therapy goals? Goals are hobbies or activities you can't currently do that you hope to be able to do after completing PT. (example: play 9 holes of golf, get dressed without pain, sit for an hour, etc):

Please mark the location(s) of your symptoms:



Summit Physical Therapy Patient Privacy Policy

Effective Date April 14, 2003

WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH A DETAILED WRITTEN NOTICE DESCRIBING HOW THIS CLINIC MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN OBTAIN OR CORRECT THIS INFORMATION.

Here is a brief summary:

- ◆ We may use your medical information or disclose it to others in order to provide or arrange your health care, to arrange payment or reimbursement for the care that we provide to you, or to carry out administrative activities related to or supporting your treatment.
- ◆ We may be required or permitted by certain state or federal laws, regulations, or legal circumstances to use or disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.
- ◆ As our patient, you have important rights regarding your medical information in this clinic. You have the right to inspect, copy, amend or correct that information, obtain an accounting of disclosures of your medical information, request that we communicate with you confidentially and request that we restrict certain uses and disclosures of your health information. We have a procedure for filing a complaint if you think your rights have been violated.
- ◆ A detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law is posted on our website at <https://summit-physicaltherapy.com/notice-of-privacy-practices/>. We may revise our notice from time to time. The effective date at the top of this page indicates the date of the most current notice in effect.
- ◆ You have the right to receive a written copy of our most current notice in effect. If you would like to receive a copy of our current notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the notice or your medical information, please contact Paul Kane of our office at (503) 699-2955.