Patient Intake

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Gender? □ Male □ Female □ Non-Binary/Third Gender □ Prefer Not to Say

Social Security ID (Why are we asking? Depending on your benefits and insurance coverage, your social security number may be required.) _____ - _____ - _____

Marital Status: □ Single □ Married □ Other: _____

In the Event of an emergency, who would you like us to contact?

First Name: _____ Last Name: _____

Phone Number: _____ Relationship: _____

How did you hear about us?

□ Doctor referral □ Direct mail □ Friend/family □ I've had PT/OT here before □ Google Review

□ Website □ Other _____

Is your injury related to any of the following? □ Auto related □ Work Related □ Other Accident Related □ None

Is there an attorney involved with your injury? □ Yes □ No

Attorney Name: _____ Phone Number: _____

If a work related, injury, please complete the following information:

Please select your employment status: □ Full-time □ Part-Time □ None

Employer Name: _____ Employer Phone Number: _____
Street Address: _____

City: _____ State: _____ Zip Code: _____

Is your order for Physical Therapy or Occupational Therapy? □ Physical Therapy □ Occupational Therapy

What special notes and/or treatments have been requested by your physician? (i.e., dry needling, aquatic therapy, etc.)

□ Dry Needling □ Aquatic Therapy □ Cupping □ Other _____

Would you like to receive appointment reminders? If so, what is your preferred method?

□ Email □ Text □ Voice □ None

I authorize the clinic staff to leave any voice messages regarding appointments and or medical information when medically necessary to the phone number on file. □ Yes □ No

I authorize the clinic staff to send email messages regarding appointments and or medical information when medically necessary to the email on file. □ Yes □ No

Insurance Information

Are you a Medicare patient? □ Yes □ No

If you answer yes, please complete the home health information.

Are you receiving home health now or have you received it in the past 60 days? □ Yes □ No

Please provide the name of the home health agency: _____

Have you recently been discharged from home health? □ Yes □ No

Please enter the date of your last home health visit: _____

Primary Insurance

Do you have insurance you'd like to use? □ Yes □ No

Insurance Plan Name: _____ Policy ID: _____

Group #: _____ Phone Number: _____

Are you the policy holder? □ Yes □ No

Please provide the insurance policy holder information (If different from you)

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Policy Holder: _____ Policy Holder Employer Name: _____

Secondary Insurance

Do you have additional insurance you'd like to use? □ Yes □ No

Insurance Plan Name: _____ Policy ID: _____

Group #: _____ Phone Number: _____

Are you the policy holder? □ Yes □ No

Please provide the insurance policy holder information (If different from you)

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Policy Holder: _____ Policy Holder Employer Name: _____

Medical Information

Please enter your height and weight: Height = ____ feet ____ inches Weight = _____ lbs

Tell us about your injury and/or symptoms.

Approximate date of injury / onset of symptoms: _____

Diagnosis as stated to you by physician: _____

Description of how injury occurred: _____

What region(s) are affected by your current symptoms?

□ Head/Neck □ Upper Back □ Shoulder □ Arm □ Hand/Wrist □ Hip □ Pelvis □ Lower Back

□ Knee □ Leg □ Ankle/Foot □ Other _____

Are you experiencing or have you experienced dizziness associated with this condition? □ Yes □ No

Have you received any previous treatment for this condition? □ Yes □ No

Please indicate any previous treatment you received for this condition: _____

Pain Level

Are you experiencing or have you experienced pain associated with this injury? □ Yes □ No

What kind of pain are you experiencing? □ Pain radiating down □ Pain radiating up □ Tenderness

□ Numbness/tingling □ Ache/pain □ None

My pain/symptoms are worse… □ In the morning □ During the day □ At night □ With activity □ At rest

□ None □ Symptoms come and go □ Symptoms are constant

My pain/symptoms are best… □ In the morning □ During the day □ At night □ With activity □ At rest

□ None □ Symptoms come and go □ Symptoms are constant

Please circle the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 to 10.

Current Pain:	0	1	2	3	4	5	6	7	8	9	10
	No pain	Mild Pain		Moderate Pain		Severe Pain		Extreme Pain		Worst Pain Ever	
Best Pain:	0	1	2	3	4	5	6	7	8	9	10
	No pain	Mild Pain		Moderate Pain		Severe Pain		Extreme Pain		Worst Pain Ever	
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
	No pain	Mild Pain		Moderate Pain		Severe Pain		Extreme Pain		Worst Pain Ever	

Have you ever had any of the following for this issue before?

Diagnostic Tests: □ MRI □ X-Ray □ CT Scan □ Myelogram □ Other _____

Surgery: Date of Surgery: _____ Description: _____

Another From of Treatment: □ Physical Therapy □ Occupational Therapy □ Speech Therapy

□ Chiropractic □ Other: _____

Hospitalization: Reason: _____ Date of Hospitalization: _____

Fall History

Have you fallen within the last year? □ Yes □ No How many times have you fallen within the last year? _____

Do you feel unsteady when standing or walking? □ Yes □ No

Do you worry about falling? □ Yes □ No

Referring Physician

□ I don't have a referring doctor

Doctor Name: _____ Phone #: _____

Referring doctor prescription date: _____ (please give a copy of your script to our front office)

Medical History

Please select the conditions that you have been or are presently being treated for. This information helps your therapist develop a treatment plan that will be best for you.

□ Acquired Respiratory Distress Syndrome □ Allergies □ Angina □ Anxiety or Panic Disorders
□ Arthritis (Osteoarthritis or Rheumatoid) □ Asthma □ Back Injury □ Bleeding disorders □ Bowel/bladder abnormalities
□ Cancer □ Chronic obstructive pulmonary disease (COPD) □ Congestive heart failure (CHF) □ Defibrillator
□ Degenerative disc disease (neck or back) □ Depression □ Diabetes □ Dizzy or fainting spells □ Emphysema
□ Epilepsy or seizure disorder □ Fracture □ Headaches □ Hearing impairment □ Heart attack Hepatitis A, B, C
□ Hernia □ High Blood Pressure □ HIV/AIDS □ Hypoglycemia □ Immunosuppressant Condition or Medication
□ Kidney problems □ Liver/gallbladder problems □ Metal implants □ Multiple sclerosis □ Nausea/vomiting
□ Osteoporosis □ Pacemaker □ Parkinson's disease □ Peripheral vascular disease □ Pregnancy □ Ringing in your ears
□ Sexual dysfunction □ Skin abnormalities □ Smoking □ Special diet guidelines □ Stroke or TIA □ Tuberculosis
□ Upper Gastrointestinal Disease □ Visual Impairment

Medications

Are you currently taking any medications? □ Yes □ No

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

For more medications than space provided, please give a list to the front office

Functional Level

What is your main complaint functionally? _____

Check all the activities that you have trouble performing as a result of your present condition:

□ Bathing □ Childcare □ Dressing □ Eating □ Homemaking □ Yard work □ Standing □ Sitting
□ Sleeping □ Walking □ Working □ Other _____

What are your goals for therapy at this time? _____

Is there any other information regarding your medical history that is important for us to know? Please list below.

_____

HIPAA Release

We are legally required to follow privacy practices. Please list who we have your permission to disclose any of your protected health information:

_____ _____

_____ _____

Patient Acknowledgements

Empower Physical Therapy consists of the following brands:
Arizona- Empower Physical Therapy
California- CoasTherapy, ProActive Physical Therapy and Sports Medicine
Louisiana- Affiliated Therapy Services
Texas- Amistad Physical Therapy, Orthopedic Physical Therapy, Premier Rehab Physical Therapy

Appointment Information

- As a courtesy, we will attempt to verify your insurance benefits prior to your initial evaluation.
- If required by your insurance, and we are unable to obtain the authorization prior to your appointment, we may have to reschedule the visit.
- Please wear loose fitting clothing suitable for physical activity, including closed toed shoes.
- Please arrive 15 minutes prior to your appointment time with your identification card, insurance card, and be prepared to fill out any additional documents.
- Children under the age of 18 must have a parent or guardian in our office during the Initial Evaluation and then is up to the discretion of the parent, patient, and therapist if a parent is to be present for follow up appointments in their entirety.
- Small children may attend appointments but must be with you at all times.
- We do not allow weapons of any kind in our clinic locations. If you carry a firearm or any other type of weapon, whether registered or not, please keep it in your car during your treatment session.

Consent for Care and Treatment

I give my consent for treatment by the staff at Empower Physical Therapy for therapy services and treatment considered medically necessary as prescribed by my physician and/or therapist.
I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at Empower Physical Therapy.

Benefit Assignment / Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to Empower Physical Therapy or one of it's associated brands, for medical benefits to which I am entitled, including Medicare, private insurance, and third-party payers for services performed during my treatment.
I authorize Empower Physical Therapy to release all information necessary including medical records to secure payment for therapy services provided by Empower Physical Therapy staff.

Cancellation Policy

We request that you provide us with at least 24 business hours' notice so we can reschedule your appointment within the same week. We reserve the right to charge a $50.00 cancellation and/or no-show fee if you fail to give us 24 hours' notice to cancel your appointment. Failure to attend your sessions will negatively impact your outcome and likely result in premature discharge from therapy services.

Patient Rights Acknowledgement

You have the right to receive treatment without discrimination or exclusion based on race, color, national origin, age, disability, sex, religion, or any other protected status.

I acknowledge that I understand the rights listed above.

Patient Financial Responsibility

- It is the patient's responsibility to notify Empower Physical Therapy personnel of any insurance change.
- Payment is due at each visit as determined by your Insurance plan contractual benefits. These quoted benefits are not a guarantee of payment and are an estimate provided by your insurance provider.
    - If your Insurance Maximum Benefit Limitations have been met/satisfied any time before/during/or after treatment with claims still pending, service amount will reflect in full charges due based on your contracted rate.
    - All past due balances must be paid prior to receiving any further treatment.
    - If a check is dishonored or returned for any reason, we reserve the right to apply the banks fees to the patient's account, per check plus the original amount of each check.
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company. The estimated amount collected at time of service will be applied to your outstanding balance, if applicable.
- Failure to respond to insurance requests for additional information may result in claim denials, which will be the patient's financial responsibility.
- The patient is financially responsible for services rendered regardless of insurance coverage or if deemed medically unnecessary by your insurance provider.
- Please alert any Empower Physical Therapy personnel if you have received any other healthcare interventions which could have utilized any of your physical or occupational therapy benefits. These services could include, but are not limited to:
    - Outpatient/In Patient Physical Therapy, Occupational/Speech Physical Therapy, Chiropractic Services, Airrosti, Home Health Care, Muscular Manipulations
- Some insurance plans require that an authorization is obtained by the primary care physician. It is the patient's responsibility to know if an Insurance Authorization is REQUIRED and obtained prior to treatment to continue receiving additional therapy services.

HIPAA Privacy Notice

Please see the additional attachment for a copy of our Notice of Privacy Practices

I acknowledge that I have reviewed and understand the Notice of Privacy Practices prior to attesting to this consent.

Please review all the information above. By signing your name at the end of this document, you acknowledge having read this form in its entirety and fully understand all the information discussed.

Printed Name: _____ Date: _____

Signature: _____