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| Patient Information (Please Print) |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| First Name |  | MI |  | Last Name |  | DOB |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Address |  | City |  | State |  | Zip |  |

|  |  |  |
| --- | --- | --- |
| Phone (     ) |  | Email: |

|  |  |  |
| --- | --- | --- |
| How do you want to receive appointment reminders? | Select 1:  Text  Phone Call  Email |  |

Sex (*required for insurance purposes*):  Male  Female

Gender if different from sex (*optiona*l):  Transgender  Gender Fluid  Non-Binary Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pronoun Preference (*optional*):  he/ him/ his  she/ her/ hers  they/ them/ theirs  Other \_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Who may we thank for referring you? | Please Indicate Whom |  |

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| --- |
| Emergency Contact |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | Phone (     ) |  | Relationship |  |

|  |
| --- |
| Problem |

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Provider |  | Primary Care Physician |  |

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| --- | --- | --- |
| Injury/ Body Part Involved |  | Right  Left |

|  |  |  |
| --- | --- | --- |
| Last MD Visit |  | Have you previously been treated by a Physical Therapist this year? Yes  No |

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| Insurance Information |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Insurance |  | Secondary Insurance |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Subscriber Name |  | Subscriber Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Subscriber DOB |  | Subscriber DOB |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship to Subscriber |  | Relationship to Subscriber |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ID # |  | Group # |  | ID # |  | Group # |  |

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| Work Related Injury or Motor Vehicle Accident |

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| --- | --- | --- | --- | --- | --- |
| Work Related | MVA | Claim No. |  | Date of Injury |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Name |  | Insurance Billing Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Claim Manager’s Name |  | Phone (     ) |  |

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| --- | --- |
| **This is not work or accident related** |  |

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| Agreement |

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid

directly to the provider of service and I am financially responsible for non-covered services. I also authorize Innova Physical Therapy to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature (Parent/ Guardian if patient is a minor) |  | Date |  |

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| --- |
| **Name:** |
| **Height:** |
| **Weight:** |



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| --- |
| PERSONAL HEALTH HISTORY |

|  |  |
| --- | --- |
| What problem/ issue brings you here today? |  |

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| Mark the areas of the body where you feel pain. Include all affected areas. Use the appropriate symbols.  **ACHE** >>>> **NUMBNESS** //// **PINS & NEEDLES** oooo **STABBING** ++++ **BURNING** xxxx  http://i.dailymail.co.uk/i/pix/2008/03_03/MarathonDiagram_468x327.jpg |

**Please check the appropriate box to describe the level of pain/ discomfort you are having today.**

|  |  |
| --- | --- |
| **0= No pain** | **10= Worst pain imaginable** |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

|  |  |
| --- | --- |
| When did your injury begin? |  |

Please describe the timing of your pain:

Worst in Morning Worst in Evening

|  |  |  |
| --- | --- | --- |
| Constant Comes and Goes Getting Worse Getting Better Keeps Me Awake | | |
| What activities aggravate your injury/problem area? |  |

|  |  |
| --- | --- |
| What activities relieve your injury/problem area? |  |

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| --- | --- |
| My current exercise program includes: |  |

Have you experienced any of the following in association with your current problem:

Locking

Buckling

Lip numbness

Giving way

Dislocating

Loss of balance

Unconsciousness

Pain with cough/sneeze

Dizziness or blurred vision

Pain with yawning

Pain with brushing teeth

Pain with eating

Please list three activities you are unable to do or are having difficulty with as a result of your problem:

**Activity**

|  |  |
| --- | --- |
| **1= Unable to perform activity** | **10= Able to perform activity as before problem** |

|  |  |  |
| --- | --- | --- |
| 1. |  | 1 2 3 4 5 6 7 8 9 10 |
|  |  |  |
| 2. |  | 1 2 3 4 5 6 7 8 9 10 |
|  |  |  |
| 3. |  | 1 2 3 4 5 6 7 8 9 10 |
|  |  |  |

Have you had any of the following tests:

|  |  |  |  |
| --- | --- | --- | --- |
| Bone Scan MRI XRAY EMG CT Scan Blood Work Injections  Coned Beam Scan Nerve Tests | | | |
|  | | | |
| Other: |  | |
|  |  | |
| Have you received treatment for your current condition? | | Yes No |

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| Physical Therapy Massage Therapy Chiropractic Acupuncture |

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| --- | --- | --- | --- | --- | --- |
| **Injection:** |  | Date: |  | Location: |  |

**Prior Surgery:** *If none, indicate N/A*

|  |  |
| --- | --- |
| **TYPE** | **DATE** |
|  |  |
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**Medications:** *If none, indicate N/A*

|  |  |
| --- | --- |
| **NAME** | **DOSAGE** |
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**Have you had any long-term use of Prednisone, Cortisone, steroids, inhalants?** Yes No

**Please check as many of the following conditions apply to you:**

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| --- | --- | --- |
| Chest Pain | Dizziness | Osteoarthritis |
| Heart Attack | Imbalance/ Frequent Falls | Rheumatoid Arthritis |
| High Blood Pressure | Severe Night Pain | Osteoporosis |
| Low Blood Pressure | Difficulty Sleeping | Tuberculosis |
| High Blood Cholesterol | Night Sweats | Cancer |
| Poor Circulation | Fatigue | Skin Rash/ Disease |
| Bleeding/ Bruising Problem | Loss of Appetite | Hepatitis |
| Blood Clots | Chills | HIV/ AIDS |
| Respiratory Disease | Vomiting | Diabetes |
| Difficulty Breathing | Nausea | Pregnancy |
| Persistent or Unusual Cough | Swollen Ankles | Smoking |
| Head Injury/ Concussion | Numbness to Hands or Feet | Unusual Stress at Home |
| Stroke | Visual/ Hearing Problems | Unusual Stress at Work |
| Seizures | Bowel/ Bladder Problems |  |
| Blackouts | Arteriosclerosis |  |

**Work:**

|  |  |  |  |
| --- | --- | --- | --- |
| Job Title |  | Employment Status |  |

|  |  |
| --- | --- |
| How physically demanding is your job? | Sedentary Light Moderate Heavy |
|  |  |

Patients who are faced with daily pain commonly experience worry, frustration and sadness. Please check the appropriate box to indicate the extent that you are troubled by the following:

**Emotional Status**

|  |  |
| --- | --- |
| **0= NONE** | **10= SEVERE** |

|  |  |
| --- | --- |
| Anxiety | 0 1 2 3 4 5 6 7 8 9 10 |

|  |  |
| --- | --- |
| Depression | 0 1 2 3 4 5 6 7 8 9 10 |

|  |  |
| --- | --- |
| Irritability | 0 1 2 3 4 5 6 7 8 9 10 |

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| --- | --- | --- |
| Did you experience anxiety or depression prior to the problem in which we are seeing you for today? | Yes | No |
| Have you received counseling for anxiety or depression? | Yes | No |
| Do you have a history of psychological disease? (ie: ADD, OCD, Bipolar, Schizophrenia) | Yes | No |

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| --- | --- |
| **Would you like to share any other information with us today?** |  |

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*I voluntarily give my permission to Innova Physical Therapy to provide therapy services and treatment to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Innova Physical Therapy, or until I withdraw my consent in writing.*

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| --- | --- | --- | --- |
| Signature (Parent/ Guardian if patient is a minor) |  | Date |  |



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| **FINANCIAL POLICY** |

**Standard Insurance Policy:**

*Innova* will bill your insurance carrier as a courtesy to you. However, you are ultimately responsible for payment for services you receive. If we are contracted with your insurance company, we must follow our contract and their requirements. **It is the insurance company that makes the final determination of your eligibility.**

**Costs you may be responsible for after insurance processes:**

**Deductible**

**Copayments**

**Non-Covered Services**

If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance company. Referrals are current for 90 days unless otherwise specified.

Copays are due at the time of service. It is your responsibility to know the amount of your copay. My copay is $      .

The balance on your monthly statement is due and payable when the statement is issued, and is past due if not paid by the due date on the statement. Payment plans are available upon request.

**Self-Pay Policy:**

*Innova* will apply a discount for patients without insurance coverage, or for those patients that have exceeded insurance benefits. Payment is due at the time services are rendered.

**Auto PIP/ Third Party Policy:**

We do not accept third-party or accident settlement *liens.* If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. We require that you allow us to bill your health insurance or pay our self-pay rates at the time of service.

**Cancellation Policy:**

The appointments made for you represent a time set aside specifically for you and your therapist. We value your time and ask that you value ours by giving at least 24 hours’ notice for any cancellations or changes to your appointment.

Patients who fail to provide **24 hours’ notice** will be charged a **$60.00 fee**. This fee is not billable to insurance and is due at your next scheduled appointment. Patients who cancel or no show on three separate occasions will be discharged from physical therapy and removed from the schedule. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge.

If you have any questions regarding this policy, please do not hesitate to contact our *Clinic Director* at: (425) 658-4980

**I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.**

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| --- | --- | --- | --- |
| Signature (Parent/ Guardian if patient is a minor) |  | Date |  |



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| **PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES** |

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act (HIPAA). I have been given the right to review and receive a copy of Innova’s Notice of Privacy Practices. I understand that Innova Physical Therapy will use or disclose my health information for treatment, billing and healthcare operation. I understand that I have the right to request in writing how my private information is used or disclosed.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature (Parent/ Guardian if patient is a minor) |  | Date |  |