Patient Information (Please Print)

First Name ______________________ MI _______ Last Name ______________________ DOB ____________

Address __________________________________ City ___________________ State _______ Zip ____________

Phone ( ) ____________________ Email: ____
FOR BILLING QUESTIONS/ CONCERNS/ INVOICES/ UPDATES

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 (*optional*): ☐ Transgender ☐ Gender Fluid ☐ Non-Binary ☐ Other ______________

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

Who may we thank for referring you? Please Indicate Whom ____

Emergency Contact (Please Print) REQUIRED

Name ________________________________ Phone ( ) __________________ Relationship ____________

Problem

Referring Provider ____________________________ Primary Care Physician ____________________________

Injury/ Body Part Involved ____ ☐ Right ☐ Left

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

Insurance Information REQUIRED

Primary Insurance ______________________________ Secondary Insurance ____________________________
REQUIRED | REQUIRED or indicate none N/A

Subscriber Name _______________________________ Subscriber Name _______________________________
REQUIRED | REQUIRED or indicate none N/A

Subscriber DOB ________________________________ Subscriber DOB ________________________________
REQUIRED | REQUIRED or indicate none N/A

Relationship to Subscriber _______________________ Relationship to Subscriber _______________________
REQUIRED | REQUIRED or indicate none N/A

ID # _______________________ Group # ___________ ID # _______________________ Group # ___________
REQUIRED | REQUIRED | REQUIRED or indicate none N/A | REQUIRED or indicate none N/A

☐ I am not providing insurance information. I am private paying for my sessions.

Work Related Injury or Motor Vehicle Accident

☐ Work Related ☐ MVA Claim No. ___________________________________ Date of Injury ____________

Insurance Name ____________________ Insurance Billing Address ______________________________________

Claim Manager's Name ____ Phone ( ) ____________

☐ **This is not work or accident related**

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 ____________

INNOVA
PHYSICAL THERAPY TRANSFORMED

Name: ______________________
Height: ______________________
Weight: ______________________

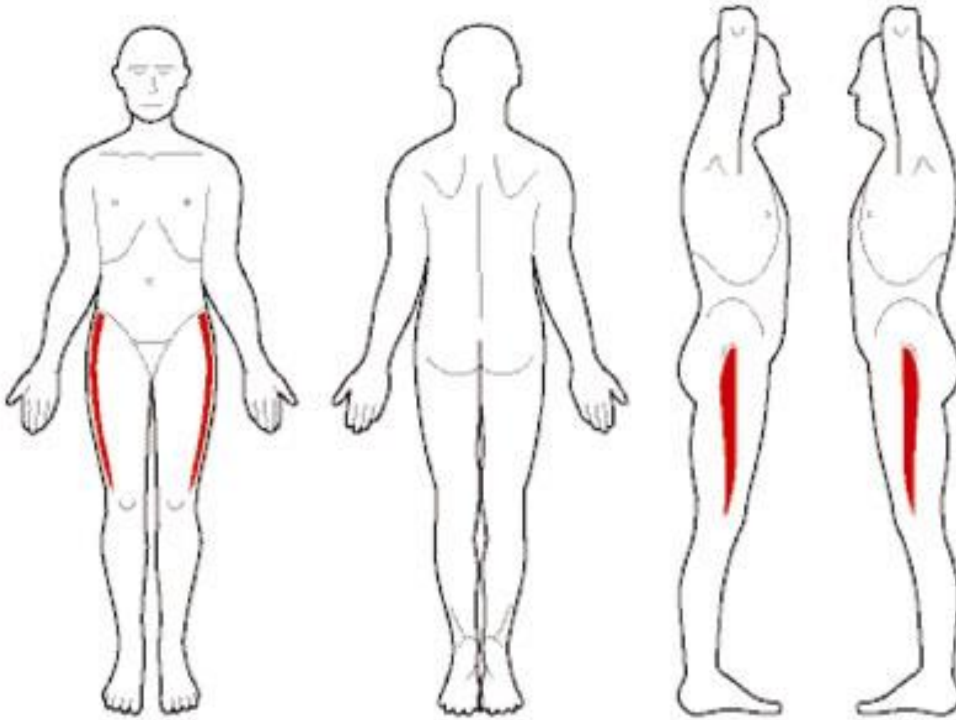
PERSONAL HEALTH HISTORY

What problem/ issue brings you here today? ____

____

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



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:

☐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? ______________________________

My current exercise program includes: ______________________________

Do you have a history of falling? ☐Yes ☐No

Have any injuries that resulted from a fall? ☐Yes ☐No

How often do you fall/ per week? ______________________________

When was your last fall? ______________________________

REQUIRED
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

Other: ______________________________

Have you received treatment for your current condition? ☐Yes ☐No

☐Physical Therapy ☐Massage Therapy ☐Chiropractic ☐Acupuncture

Injection: ______________ Date: __________ Location: __________

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

TYPE	DATE

Medications: REQUIRED *If none, indicate N/A*

NAME	DOSAGE

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

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

____

____

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

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

Would you like to share any other information with us today? ______________________________

____

____

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.

Signature (Parent/ Guardian if patient is a minor) ______________________________ Date __________

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.

Signature (Parent/ Guardian if patient is a minor)__________________________________Date____________

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____________