INNOVA
PHYSICAL THERAPY TRANSFORMED

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 _____ (REQUIRED) Secondary Insurance _____ (REQUIRED or indicate none N/A)

Subscriber Name _____ (REQUIRED) Subscriber Name _____ (REQUIRED or indicate none N/A)

Subscriber DOB _____ (REQUIRED) Subscriber DOB _____ (REQUIRED or indicate none N/A)

Relationship to Subscriber _____ (REQUIRED) Relationship to Subscriber _____ (REQUIRED or indicate none N/A)

ID # _____ (REQUIRED) Group # _____ (REQUIRED) ID # _____ (REQUIRED or indicate none N/A) Group # _____ (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: _____

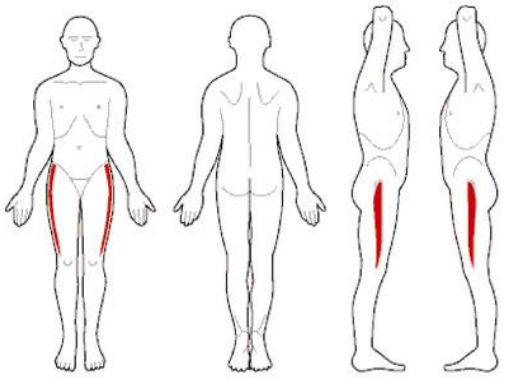
PERSONAL HEALTH HISTORY

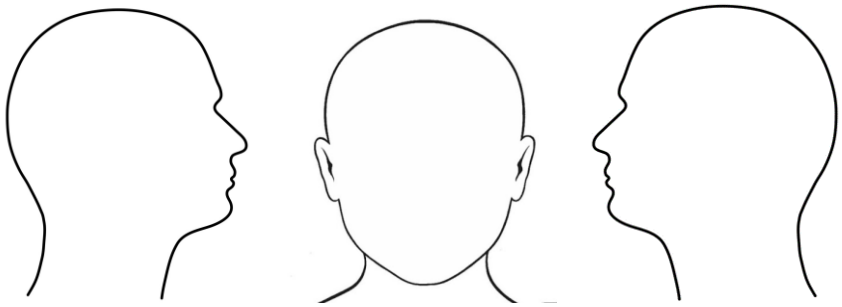
What problem/ issue brings you here today? _____

_____

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:
☐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? _____

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

☐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

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:

☐ 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

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 _____

PHYSICAL THERAPY TRANSFORMED

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_____

PHYSICAL THERAPY TRANSFORMED

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 _____