Physical Rehabilitation Services, LLC

Patient Intake Form - Page 1

Please provide medical insurance card(s), photo ID, and auto insurance card (if applicable) to front desk upon arrival.

PERSONAL

Patient Name:_____ **DOB:**_____ **SEX:**___ **SSN #:** _____-____-_____

Address:_____ **City:** _____ **State:** _____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

Referring Physician/NP/PA:_____ **Referring Provider Phone#:**_____

Primary Care Physician:_____ **PCP Phone#:**_____

INSURANCE

Primary Insurance: _____ **Member ID:**_____ **Group #:**_____

Secondary Insurance: _____ **Member ID:**_____ **Group #:**_____

HRA/HSA/FSA? (Do you have a Health Savings Account/Flex Savings Account) Y / N

Guarantor: Self / Spouse / Parent / Child / Other _____ **Name:**_____ **DOB:**_____

REASON FOR TREATMENT

Is your complaint related to: (Check all that apply then fill out applicable information)

- ❑ **1. Work Injury**
- ❑ **2. Motor Vehicle Accident**
- ❑ **3. Sport Injury**
- ❑ **4. Other Injury**
- ❑ **5. None of the Above**

If you checked box(es) 1-4 please fill out this section:

- → Date of Injury_____ State of Injury_____
- → Third Party Insurance Name:_____
- → CLAIM #_____
- → Adjuster Name_____ Phone#_____
- → Attorney Name_____ Phone#_____

EMERGENCY INFORMATION

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone#**_____

Advanced Directive? Y / N Do you wish to be resuscitated in the event of a cardiovascular emergency? Y / N

OTHER

Preferred Facility:

- ❑ 860 Main St, Wintersville, OH 43953
  (P) 740-264-9500 (F) 740-266-6394
- ❑ 1007 Franklin St, Toronto, OH 43964
  (P) 740-537-2000 (F) 740-537-9440

How did you hear about us? *(Check all that apply)*

- ❑ **TV**
- ❑ **Radio**
- ❑ **Newspaper**
- ❑ **Doctor**
- ❑ **Friend**
- ❑ **Relative**
- ❑ **Phonebook**
- ❑ **Google/Bing Search**
- ❑ **Google Maps**
- ❑ **Website**
- ❑ **Facebook**
- ❑ **Other** _____

I have completed the information in this document accurately to the best of my knowledge. By signing this, I consent to receive appointment reminders via text, voice, and/or email. I can opt out of these reminders at any time by speaking with the staff.

Name of Person Filling out this form_____ **Relationship to Patient:**_____

Signature: _____ **Date:**_____

Thank you for choosing Physical Therapy Associates!

Physical Rehabilitation Services, LLC

Patient Intake Form - Page 2

HEALTH HISTORY

Please rate your current overall health (circle): Excellent Good Fair Poor

Do you currently do any of the following activities. Check all that apply.

- ❑ Exercise? What kind?_____
  ____Times a Week for ___minutes each time.
- ❑ Smoke? (Circle Type) Cigarettes/Cigars/Pipes/E-Cigs
  ____X Per Day / ___Days Per Week / Only Socially/ Rarely
- ❑ Smokeless tobacco? (Circle Type) Cans/Pouches
  ____X Per Day / ___Days Per Week / Only Socially/ Rarely
- ❑ Drink Alcohol? (Circle Type) Beer/Wine/Liquor
  ____X Per Day / ___Days Per Week / Only Socially/ Rarely
- ❑ Illicit Drugs (Marijuana/Non-Prescription Opioids/Heroin/Cocaine)
  ____X Per Day / ___Days Per Week / Only Socially/ Rarely

ALLERGIES

Are you allergic to any of the following?

- ❑ Drugs/Medications: List Drug(s) and Describe Reaction(RXN): _____
  _____
  _____
- ❑ Food: Type & RXN:_____
- ❑ Animals: Type & RXN:_____
- ❑ Pollen/Seasonal Allergies
- ❑ Other _____ RXN(s)_____

Are you a previous tobacco user? Y / N If Yes, Year started _____ Year quit _____ Type: Cigarettes, Cigars, Snuff, _____

MEDICATION

List any Prescription Medications you are currently taking. ❑ Copy of List Attached

FAMILY HISTORY

Do you or a family member have a history of the following?

	You	Mother	Father	Son	Daughter	Grandmother	Grandfather
Heart Disease							
Heart Problems							
Hypertension							
Stroke							
Diabetes							
Cancer(Type)							
Psychologic							
Arthritis (type)							
Osteoporosis							
Prostate Disease							

WOMEN ONLY

Have you ever been diagnosed with:	Y	N
Pelvic inflammatory disease?		
Endometriosis?		
Trouble with period?		
Trouble with pregnancy?		
Complicated Pregnancies/Deliveries?		
Other OB/GYN?		

Are you pregnant: No Yes Maybe

If you answered yes to any of the above, please provide year and explanation here:_____

SURGICAL HISTORY

Please List All Surgeries and Year(s) Here:_____

Do you have any other medical condition of which we should be aware? _____

Thank you for choosing Physical Therapy Associates!

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF PATIENT RECORDS and CONSENT TO EXAMINATION/TREATMENT

By signing this document, I authorize Physical Rehabilitation Services, LLC dba Physical Therapy Associates to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Physical Rehabilitation Services, LLC dba Physical Therapy Associates, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations. This Assignment of Benefits is irrevocable.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the minor patient. I am authorized to provide said consent for the minor patient. I acknowledge that there are benefits, risks, and alternatives to the treatment being provided. You are encouraged to discuss any questions you may have with your provider or staff member.

FINANCIAL POLICIES

Insurance

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Coverage for outpatient rehabilitation services varies from plan to plan. Most insurance policies require the beneficiary to pay a co-insurance, co-payment and/or a deductible. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations. Your insurance pays on your behalf, but ***you*** are ultimately responsible for all costs of treatment. By signing this document, you are authorizing us to submit claims to your medical insurance and/or auto insurance (where applicable) and to directly receive reimbursement from those sources.

Motor Vehicle Accident/Personal Injury

You acknowledge that we have a right to recover the full balance due on your account from you and/or any financial settlement that may arise from a motor vehicle accident or personal injury case(s) in which we have rendered services associated with said case(s). By signing this document, you are permitting Physical Rehabilitation Services, LLC dba Physical Therapy Associates to submit invoices for payment to your auto insurance carrier where appropriate.

Workers' Compensation

We accept patients treated through Workers' Compensation. Prior authorization through an MCO is required in Ohio. Please provide all information you have pertaining to your case worker and treating provider(s). If your case is denied, ***you*** will be personally liable for all incurred charges associated with your care.

Attorney

You must inform us if you have retained an attorney with regard to any conditions that we are treating/evaluating.

Patient Records

We assess the maximum fee schedule permissible by law for the procurement of patient records. Fees will be assessed for a patient requesting personal records and for third parties (i.e. attorneys) requesting patient records.

I certify that I have read, or have had read to me, and understand the information in this document. I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Print Name: _____ **Signature:** _____ **Date:** _____

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES

This form will be retained in your medical record.

Notice to Patient

We are required to offer you a copy of our Notice of Privacy Practices. It states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this Notice. I acknowledge that I have been offered a copy and the opportunity to review the Notice of Privacy Practices on the date below on behalf of Physical Rehabilitation Services, LLC dba Physical Therapy Associates.

I understand that the Notice describes the uses and disclosures of my protected health information by Physical Rehabilitation Services, LLC dba Physical Therapy Associates and informs me of my rights with respect to my protected health information.

Patient Name (printed) _____ **Patient Date of Birth:** _____

Legal Guardian Name, IF applicable (printed) _____

Patient/Legal Guardian Signature _____ **Today's Date:** _____

Thank you for choosing Physical Therapy Associates!

Physical Rehabilitation Services, LLC

History of Present Illness

To be filled out and handed to Healthcare Provider

Patient Name: _____ Date: _____

WHAT BRINGS YOU HERE TODAY? (Each body part will need a separate sheet)

Chief Complaint/Symptom/Body Part: _____

How Long have you been experiencing these symptoms? If you know exact date please provide it. _____

SYMPTOM INTENSITY: (Only describe your symptom listed above)

On a Scale from 1-10, with 1 being NO PAIN AT ALL, and 10 being the WORST PAIN POSSIBLE, Please Rate the Following:

Pain/Symptom You're Feeling *RIGHT NOW*: _____ **Pain/Symptom at its *WORST*:** _____ **Pain/Symptom at its *BEST*:** _____

What makes your symptom feel BETTER? _____ **WORSE?** _____

Is there a time of day that your symptom worsens? Y / N If Yes Please Explain: _____

SYMPTOM DESCRIPTION:

Please check all that describe your current symptom listed above:

❑ Sharp	❑ Achy	❑ Piercing	❑ Nagging	❑ Tight	❑ Other	
❑ Dull	❑ Burning	❑ Stabbing	❑ Shooting	❑ Tingling	_____	
❑ Stiff	❑ Throbbing	❑ Deep	❑ Stinging	❑ Numbness	_____	

Does your symptom radiate into another body part? Y / N If Yes Please Explain: _____

FOR OFFICE USE ONLY

Provider Notes: _____

Steubenville Office:
320 S Hollywood Blvd
Steubenville, OH 43952
P: 740-264-5559
F: 740-264-5355

PHYSICAL THERAPY ASSOCIATES

Toronto Office
1007 Franklin St
Toronto, OH 43964
P: 740-537-2000
F: 740-537-9440

Wintersville (MAIN) Office:
860 Main St, Wintersville, OH 43953
P: 740-264-9500 F: 740-266-6394

Patient Release of Medical Records

I hereby give consent to the Physical Rehabilitation Services, LLC dba Physical Therapy Associates to have access to all medical records. This patient record release will automatically expire one (1) year from the date of this signature.

Patient Date of Birth: _____

Patient Name (printed) _____

Patient Signature _____

Today's Date: _____