Physical Therapy Health History Intake Forms

Name: _____ Gender: M F Date: _____

Address: _____ State: _____ Zip: _____

Phone: (_____)_____ Email: _____ DOB: _____

Age: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

Have you ever received Physical Therapy? Yes / No If yes, when and by whom? _____

INSURANCE INFORMATION

Name of party responsible for payment: _____

Insurance Company Name: _____

Subscriber ID: _____ Group Number: _____

PRIMARY REASON FOR PHYSICAL THERAPY:

Primary Reason: _____ Date complaint began: _____

Referring Physician: _____ Office Number: _____

Have you had x-rays or MRI of this area? _____ If so, when and where? _____

Does your pain interfere with any of the following: (circle all that apply)

Sitting Walking Standing Lifting Traveling Personal Care Social Activities

Grade Intensity/Severity (circle one): 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Frequency of Pain (circle one): Occasional Intermittent Only with certain movements Constant

Previous interventions, treatments, medications, or surgery sought for this concern:

_____

_____

_____

Past Health History:

1. **Any significant current or previous illnesses? _____**
2. **Any previous injuries or traumas? _____**
3. **Any Hospitalizations? _____**
4. **Have you ever broken any bones? Which? _____**
5. **Any sprains/ Strains? _____**
6. **Allergies: _____**
7. **List of current medications? (list on back if necessary)**

   _____

   _____
8. **Taking any vitamins/supplements? _____**
9. **Please list any medical/health history of family members: (heart disease, diabetes, cancer etc)**

   _____

   _____

   _____
10. **Occupation: _____ Employer: _____**
11. **Recreational activities: _____ Exercise habits: _____**

Lifestyle

	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Exercise				
Sleep				
Water				
Appetite				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. Furthermore, I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient (or guardian's) Signature: _____ Date: _____

Appointment Reminder Consent

Complete this form and sign below to give permission for Knoxville Spine and Sports to provide automatic appointment reminder service by email or by cell phone text message.

Send email messages to confirm appointments to: _____

Send sell phone text messages to confirm my upcoming appointments to: _____

Cellular provider: _____

*I recognize that normal text messaging rates may apply.

Appointment reminders will be sent 24 hours in advance of appointment unless otherwise requested. We do require a 24 hour notice for any changes to the schedule. Failure to notify the office of any appointment change without 24 hours notice will result in a $25.00 charge.

Patient Signature: _____ Date: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Knoxville Spine and Sports to furnish care and treatment to (patient) _____ that is considered necessary and proper in diagnosing or treating my/his/her condition.

RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Knoxville Spine and Sports may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Knoxville Spine and Sports for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Knoxville Spine and Sports may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Knoxville Spine and Sports' charges, including but not limited to government agencies(e.g. insurance companies, health care service plans, or workers compensation carriers).

BENEFIT ASSIGNMENT: I hereby assign medical benefits to which I am entitled by private insurance and third party payers, to Knoxville Spine and Sports. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT: The patient is responsible for providing payment at the time of service for all co pays, deductibles, coinsurance and any remaining balance due from services that are not covered by the patient's insurance carrier. I understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed including original charges, interest, collection agency fees, and attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS: It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We have called your insurance company for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

CANCELLATION AND MISSED APPOINTMENT POLICY: Failure to provide 24 hours advanced notice of cancellation will incur a $25.00 fee automatically charged to your account. In instances of repeated non-compliance with our scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician that your service has been discontinues due to non-compliance with the prescribed rehabilitation order.

WORKER'S COMPENSATION CLAUSE: The above financial policy does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At the time, our Financial Policy will apply to you.

I have read the above information and understand my responsibilities.

_____ _____

Patient's Name (Print) Patient's / Guardian Signature Date

HIPAA RELEASE/PRIVACY FORM

Patient Name: _____ Date of Birth: _____

RELEASE of information:

☐ I authorize the release of information including the diagnosis, records, examination, rendered to me and claims information

This information may be released to :

☐ **Knoxville Spine and Sports**

☐ Spouse: _____

☐ Children: _____

☐ Other: _____

☐ Information is NOT to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

For phone messages, please call my…

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Work Phone: _____

If unable to reach me,

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Do not leave a message

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out: treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (i.e. insurance companies), and the day to day healthcare operation of Knoxville Spine and Sports.

I understand that I have the right to request restrictions on hoe my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, then you are bound to comply with this restriction. I understand that I may revoke this consent in writing at any time.

Patient (or parent/guardian) Signature: _____ Date: _____