Patient Intake Information

Front Range Therapies Castle Rock

Name____ Date:____________________

Address____

City_____________________________State_______Zip____________

Date of Birth________________________ Age_________ Sex: M / F

Injury and/or Surgery Date:_____________ Is this injury related to: work__ auto__ other__

Reason for visit/Injury Area:___________________________

Phone_(_____)___________________ ☐ Home ☐ Cell ☐ Work Other phone_______________

☐ Yes ☐ No May we call you at home?
☐ Yes ☐ No May we leave a voicemail message if there is no answer?
☐ Yes ☐ No May we leave a message with another person?
☐ Yes ☐ No May we call you at work? __(____)_________________

Email______________________________(for occasional newsletter and clinic updates)

I hereby authorize this provider and its employees, agents, and assignees to contact me via e-mail and text messaging. Yes / No (please circle)

SSN________________________________ Driver's License #________________________

Employer_________________________________Occupation_______________________

Referring physician_________________________

Who referred you to us, if not a physician?_______________________________

Below is insurance information. Although we also have a copy of your insurance card, we ask that you please fill in this section as well. Completing this information demonstrates that you understand your insurance benefits and responsibilities. Insurance can only be billed if you fill out all the requested information. Thank you.

Health Insurance Company____

Patient's relationship to insured: self_____ child_____ spouse_____ other_____

Medicare/Insurance ID#_____________________________ Group # _____________

Insured's name if different from patient_________________________SSN___________

Insured's address________________________________Employer__________________

Insured's DOB__________________Phone___________________

If auto/workers comp, claim #_____________Claim adjustor/contact_________________

Supplemental Insurance (if applicable)____

Supplemental Insurance ID#_____________________ Group #______________

Are you currently receiving Home Health Care? Yes / No (please circle)

Relative/Friend not living with you (contact in case of emergency)

____

Emergency contact person's address____

City_____________________State________Zip__________Phone_(____)__________

Patient Name:________________________________ Date:_______________

Medical History

PLEASE CHECK YES OR NO IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Alcohol / drug dependency problem			**HIV / AIDS**		
Allergies			**Kidney Disease**		
Anemia			**Nervous/emotional conditions**		
Bleeding disorder			**Neurological conditions**		
Bowel / bladder problems			**Osteoarthritis**		
Cancer – Date & Type / Location			**Osteoporosis / osteopenia (circle)**		
Choking / swallowing issues			**Pacemaker or defibrillator**		
Diabetes (Type I or Type II- circle)			**Pregnancy**		
Dizziness / nausea / vertigo (circle)			**Pulmonary condition**		
Fractures			**Rheumatoid arthritis**		
Have you had 2 or more falls in the past year?			**Seizures**		
Head injury			**Shortness of breath / asthma**		
Heart attack / heart disease (circle)			**Stroke / TIA (circle)**		
Heart murmur / abnormal heart beat (circle)			**Thyroid problems**		
Hepatitis and/or liver disease			**Tuberculosis**		
Hernia			**Unexplained weight loss of more than 10 lbs over the past month**		
High / low blood pressure (circle)					

List all surgeries or invasive procedures:

____

____

Other medical conditions (specify specific allergies, if applicable):

____

____

Current List of Medications

_____________________________ _______________________

PATIENT'S NAME PATIENT'S BIRTHDATE

Please list all prescribed medications, over the counter medications, dietary supplements, herbal remedies, vitamins, minerals, illegal drugs, etc.,.

Medication or other	Dosage	Frequency (ie times per day)	Route (oral, IV, drops, cream)	Last Taken

☐ Check this box if an *attached list of medications* is provided and a copy is in the chart.
☐ *Check this box if there are no medications* or other items to be mentioned.
☐ Check this box if *someone other than the patient* completed this form. Please then provide the name and signature of the person completing this form below.

______________________________ ________________________

PATIENT SIGNATURE DATE

______________________________ ________________________

PROVIDER SIGNATURE (review only) DATE

Note: only a pharmacist and/or the prescribing physician(s) can make determinations of proper dosage, interactions, side effects, etc.,. This form is a review and has been deemed a necessary part of your intake paperwork by Medicare.

PAYMENT POLICY AND BILLING PROCEDURES

Unless 100% coverage has been verified with no copay, no co-insurance, and no deductible, you are responsible for the copay/co-insurance per visit and /or deductible not covered by your insurance company. This payment is required at the time of each visit. Most insurances ask for a submitted physical therapy initial evaluation in order to authorize treatment sessions. Following the initial evaluation visit, we will assist with verifying your physical therapy sessions and will review with you the patient financial responsibilities. We suggest you read your policy manual as well, in order to better understand your coverages. We accept cash, check, and Visa/Mastercard for your payments. There is a $25.00 charge for all returned checks. You will receive a statement that will show you the status of your account.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your claim with your insurance company; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to Physical Therapy. Many insurance companies have stipulations that limit the benefit in some way, such as number of visits, supplies, and deductibles. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payment arrangements accordingly. Workers Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become your responsibility. I hereby authorize that the payment of medical benefits be made directly to Front Range Therapies Castle Rock for any services that are reimbursable by my insurance or any third party sources.

SUPPLIES/MEDICAL RECORDS POLICY

Payment for all supplies not covered by insurance is due at the time of service. Medicare patients: Medicare does not cover supplies. You are responsible for payments for all supplies used in your treatment at time of each visit. Items not covered by your insurance are your responsibility.

Medical records are provided within 30 days after the date of your request. Medical records are billed out at .60 per page. Payment is required before records will be released.

CONSENT TO TREATMENT

I understand I have been referred by my physician or myself for treatment and care to Front Range Therapies Castle Rock. Front Range Therapies Castle Rock has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered before receiving any treatment, including any risks or alternative to the treatment plan that was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Front Range Therapies Castle Rock provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of Front Range Therapies Castle Rock. I hereby authorize Front Range Therapies Castle Rock to furnish my insurance company(s), attorney, physician, or legal representative all information, which said parties might request concerning my present illness or injury. I hereby assign Front Range Therapies Castle Rock all money to which I am entitled for medical expenses related to the service reported herein, but not exceed my indebtedness to Front Range Therapies Castle Rock. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I am financially responsible to Front Range Therapies Castle Rock for charges not covered by my insurance company including, but limited to, collection and attorney fees, if applicable. I certify by my signature that I have read and agree to this information.

Patient Name (Print)____

Patient Signature____Date___________

Parent or Guardian Name (Print)____

Parent or Guardian Signature____

ATTENDANCE POLICY

It is our policy at Front Range Therapies Castle Rock to give prompt, courteous service to all our patients. In order for us to deliver service in this manner, we schedule individual appointments. We try to schedule these appointments so that they are convenient to you. It is important for you to arrange your schedule so that you can be on time for these appointments.

If you are unable to attend or you will be late for your appointment, please notify the clinic in advance. If necessary, at that time you can reschedule the missed appointment. Failure to attend your session may hinder your recovery process. We urge you to call 24 hours prior to your scheduled appointment if you need to cancel your appointment. **I understand that a charge of $50.00 will be made to the patient for any appointment that is missed or canceled without 24 hours notice. This fee is not to be charged to insurance and will be collected from the patient.** Two no-shows and/or canceled visits without proper notification will result in discharge from physical therapy and your referring physician will be notified. We hope you take your therapy and recovery as seriously as we do.

If you are covered by worker's compensation insurance and you fail to keep the appointments that are recommended by your therapist and physician, the appropriate parties need to be notified of your absence and will also be noted in your chart. This may include your physician, employer, insurance company, and case manager/nurse. Please understand that failure to actively participate in your rehabilitation program may have a negative effect on your worker's compensation coverage.

ACKNOWLEDGEMENT AND DISCLOSURE TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

I acknowledge that I have received a copy of Front Range Therapies Castle Rock Privacy Practices. By signing below I consent to FRTCR use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I also confirm that I DO NOT desire restriction on FRTCR use or disclosure of protected health information for treatment, payment, and healthcare operations.

There may be times when it is necessary for an individual directly involved in your care to call our facility to inquire about your personal health information or billing information. I authorize FRTCR to disclose my health information that is directly related to my current treatment at FRTCR to these individual(s), for purposes of their role in my treatment or payment for the health services that I have received.

There may be such persons involved in your care such as spouse, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors, and colleagues. By listing these individuals below and signing below, you authorize FRTCR to release personal health information to them. If there are no such persons, leave blank.

NAME	RELATIONSHIP

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:
☐power of attorney ☐guardian ☐surrogate decision-maker
☐executor of legal rep. ☐parent ☐other (specify)___________________________________

☐ I DO desire restrictions on FRTCR use or disclosure of protected health information for treatment, payment, and healthcare operations. In doing so, I elect to pay for all services up front. I request the following restrictions listed below:

____ ____________________
Signature of patient or patient's representative Date