PATIENT DEMOGRAPHICS
INTAKE FORM

First Name:______________________________ Last Name:____

Preferred First Name:______________________________ Date of Birth:___________________

Street Address:____

City:____ State:_____________ Zip:_____________________

What is the best way to contact you? ____

Cell Phone #:________________________________ Home Phone #:_____________________________

Work Phone #:______________________________ Email:____

Occupation:____

****Have you had physical therapy in the last 12 months?** □ ***Yes -approximately how many visits_____*** □ ***No***

HEALTH INSURANCE INFORMATION

Please be sure you are familiar with your health plan's benefits for PT. (i.e. co-pay, deductible, number of visits allowed, authorization/referral requirements)

Insurance Type:_______________________________________ Member ID/Policy #:____________________________

Subscriber's Name:_______________________________________ Relationship:_________________________

Subscriber's Date of Birth:__________________ Secondary Insurance (Type & ID) #:_________________________

REFERRAL INFORMATION

How did you hear about us?____

Referring Physician:____ Phone #:____________________________

Primary Care Physician:____ Phone #:____________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:____ Relationship:_______________________

Home Phone #:_______________________________ Cell Phone #:_______________________________

MEDICAL HISTORY: INTAKE FORM

Describe your current problem and how it began:____

____

____

Onset Date: _____________ **This problem is from**: □ *Sports* □ *Work* □ *Car Accident* □ *Other*:__________

Describe the nature of your pain: □ *Sharp* □ *Dull* Ache □ *Shooting* □ *Tingling* □ *Other*:____________

My symptoms are present: □ *Constantly (76-100% of the day)* □ *Occasionally (26-50% of the day)*

□ *Frequently (51-75% of the day)* □ *Intermittently (0-25% of the day)*

What makes your symptoms <u>worse</u>? □ *Sitting for ___ mins* □ *Standing for ___ mins* □ *Walking for ___ mins*
□ *Stairs* □ *Lying Down* □ *Standing up from a chair* □ *Reaching overhead* □ *Reaching behind back*
□ *Other:*____

What makes your symptoms <u>better</u>? □ *Sitting* □ *Standing* □ *Lying down* □ *Walking* □ *Massage* □ *Chiropractor*
□ *Ice* □ *Heat* □ *Rest* □ *Other:*_______________________________________

Current Pain (0-10):_________ **Pain at Worst** (0-10):_________ **Pain at Best** (0-10):_________

How is your condition changing: □ *Getting better* □ *Getting worse* □ *Not changing*

Who have you seen for this condition (please list name)?
□ *Medical Doctor:* ___________________________ □ *Chiropractor:* _________________________________
□ *Massage Therapist:* ________________________ □ *Physical Therapist:* ____________________________ □ *Acupuncturist:* _____________________________ □ *Other:* _______________________________________

Have you had imaging (x-rays, MRI, CT Scan) for this problem? □ *No* □ *Yes (details):*______________________

How would your rate your overall health right now? □ *Excellent* □ *Very Good* □ *Good* □ *Fair* □ *Poor*

Do you exercise regularly? □ *No* □ *Yes, how often & what type?* _______________________________________

Recreational Activities/Hobbies:____

Preferred learning method: □ *Video* □ *Picture* □ *Written*

Please check all of the following that apply to you:
□ Pain at night □ Asthma / difficulty breathing □ Diabetes
□ Numbness □ Difficulty seeing or hearing □ Blood Disorder: __________________ □ Arthritis □ High blood pressure □ Cardiac Condition: ________________ □ Osteoporosis □ Abnormal weight gain / loss □ Cancer / Tumor: _________________ □ Dizziness / Fainting □ Pain unrelieved by position or rest □ Urinary problems
Other health problems: ____
Current Medications (name & dosage) ____
Prior injuries (injury & date): ____
Prior surgeries (type & date): ____

Acknowledgement of Privacy Practices

I have received, read, and understand the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Consent to Treatment

I, the undersigned, a patient at Central Mass Physical Therapy & Wellness (“CMPT”), do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Patient Coverage and Financial Responsibility

I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that CMPT will prepare insurance forms, and will bill my insurance company as a courtesy. However, I clearly understand that I am personally responsible for payment for services rendered to me.

Deductibles/Co-Insurance and/or Co-payments:

- Any copayment, co-insurance, or a $50 prepayment toward my deductible, will be collected at the time of service. Accounts will be credited, if necessary, after claims are processed by insurance.
- I agree to receive statements regarding any uncollected patient balances via email or text.
- If I opt to have CMPT maintain my signature and credit card information securely on-file in my account, I authorize CMPT to charge my credit card for any outstanding balances when they become due.
- I understand that CMPT reserves the right to discontinue treatment if an accumulating patient balance exceeds $150.00.

Insurance Referrals

Patients are responsible to ensure that referrals and authorizations required by insurance companies are obtained. As a courtesy, CMPT will assist patients with this process. Patients will be held responsible for the cost of visits that are denied by insurance because a referral or authorization was not obtained.

By signing below you are agreeing to acknowledgement of privacy practices along with all of the terms and conditions listed above.

Printed Name: ____

Signature: ____ **Date:** _________________________

Witness: ____ **Date:** _________________________

CENTRAL MASS
Physical Therapy & Wellness

CANCELLATION/NO SHOW POLICY:

Thank you for entrusting CMPT with your Physical Therapy Care!

Due to the high volume of patients and demands on our schedule, and to remain consistent with our mission of providing one-on-one care, we will be strictly enforcing the following cancellation/no show policy, **effective July 1, 2023.**

- ★ **For any cancellation made less than 24 hours before a scheduled appointment a $35 fee will be assessed.**
- ★ **A "No Show", "No Call", or missed appointment will be assessed a $75 fee.**
- ★ **The fee is charged to you–the patient, not the insurance company, and is due at the time of your next office visit.**
- ★ **Consecutive no-shows will result in automatic cancellation of all of your future appointments.**

By signing below I am indicating I have read, understand, and agree to comply with the CMPT no show and cancellation policy.

Patient Signature (Parent/Legal Guardian)____

Relationship to Patient____

Date:_______/_______/_______