TOTAL FUNCTION
Physical Therapy PC

PATIENT INTAKE FORM

Patient Information, Fill Out Completely

Patient's SS# - -	DOB: / /	Age:	Gender: M / F	Marital Status: M S D W Other

First Name	Middle	Last Name	Nickname, if any

Street Address	City	State	Zip

Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -

Preferred Number? ☐ Home ☐ Cell ☐ Work	Check if we may leave messages? ☐ Home ☐ Cell ☐ Work

Employer:	Employer Address:
Email:	
Height (in inches):	Weight (in lbs):

Insurance Information

Insurance / Payment Method: ☐ GROUP/PRIVATE INURANCE☐ VA ☐ SELF PAY ☐ MEDICARE ☐ AUTO ☐ WORKMANS COMP

Name of Insurance Company:	ID / Policy #:	Group #	Insurance Phone #

Policy holder's Name:	Policy holder's SS#	Policy holder's DOB: / /
Policy holder's Relationship to patient:	Policy holder's employer :	

Workman's Comp/Auto Insurance Information

Insurance Name	Claim #	Date of Injury / /
Adjustor Name	Phone ( ) -	Ext

Is there an attorney involved?: ☐ Yes ☐ No	If yes, Attorney's Name:	Attorney's Phone ( ) -

Emergency Contact Information

In case of an Emergency please contact :		
Relationship	Phone ( ) -	May we speak to them about your care? ☐ Yes ☐ No

Referral Information

Referred By:	PCP, if different:
Referring Physician:	Referring Physician Company:

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New Patient Information

Welcome to Total Function Physical Therapy, PC

We would like to thank you for choosing Total Function Physical Therapy, PC. We want to assure that your experience with us will be a pleasant one. Here is some of what you can expect on your first visit:

- Please arrive at **least 30 min early** on your first visit so that we may obtain copies of necessary insurance information, and you will be required to fill out a Patient History Form regarding your symptoms.
- Please dress appropriately for your physical therapy sessions. We require that you **wear comfortable clothing and footwear** when you come to your appointments. Any type of loose clothing is suitable. Sweatshirts, sweatpants, shorts, and t-shirts usually work well. Dresses, skirts, jeans and any tight clothing are not recommended.
- It is ok if you are on medication for your symptoms; continue your medication as prescribed by your physician.
- Expect to spend **approximately one hour at our clinic for your first visit**. After that, your appointments will be approximately 45 minutes in duration; treatment time includes therapist's documentation time.
- If you have any special needs, questions, or concerns about your initial visit, **please do not hesitate to contact us** and we will be more than happy to assist you.
- We are required by law to maintain the privacy of your health information and to make available to you this description of our privacy practices. We will abide by the terms of this notice and will notify you if we cannot agree to a specific restriction that you may have requested. We will accommodate reasonable requests you may have to communicate health information by alternative means or alternative location
- Your first visit will include an Initial Evaluation by your physical therapist. Your physical therapist will perform an examination to identify current and potential problems. Based on the results of the examination, and considering your specific goals, your physical therapist will design a Plan of Care to include specific interventions and will propose a timetable to achieve these goals and optimize your movement and function. Your physical therapist will likely provide you with instructions to perform exercises at home to facilitate your recovery.
- You should feel comfortable asking your physical therapist any questions regarding your Plan of Care, including specifics regarding interventions and expectations.

Cancellation & "No Show" Policy:
We appreciate your efforts to help us by arriving for your appointment on time. You are a very important member of our rehabilitation team. Our intention is to keep your appointments on schedule in conjunction with the Plan of Care that you and your therapist will commit to during your initial evaluation. Our goal is to achieve optimal outcomes with you while you are receiving rehabilitation. We will do our best to start your treatments promptly. If you need to cancel or reschedule an appointment, make sure the cancellation is OVER 24hrs before the appointment time or we will bill you a $40 cancellation fee, the third time it happens it will be $75 per missed visit.
For example, you cannot cancel your appointment for 10:30 am at 5:30pm the previous day. Based on availability, we will do our best to move your appointment to a different time or location that same day to help you avoid the $40 fee.
If three or more cancellations occur for any reason, we will discuss the need for a change in your treatment plan and advise your physician. If you fail to keep an appointment and have not called to cancel, the appointment will be considered a "no show" and after 3 "no shows" you will be discharged from therapy.
I agree to Total Function Physical Therapy's cancellation policy and agree to give 24hr notice of cancellation or be charged a $40.00 "no show" fee. After three consecutive "no shows" I understand that I will be discharged from therapy and a new prescription will be required to restart treatment.

Printed Name: _____

Patient Signature: _____ **Date:** ____ / _____ / _____

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HIPAA Release Form

I hereby authorize use of disclosure of Protected Health Information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the request to use or disclosure of Protected Health Information about me; any and all physicians, hospitals, clinics, medical care providers, insurance entities and government entities.
2. The following person or class of persons may receive disclosure of Protected Health Information about me: any representative of Total Function Physical Therapy PC, 502 E Pikes Peak Av #110, Colorado Springs, CO 80903.
3. The specific information that should be disclosed is: any and all medical records, medical history forms, pain diagrams, narrative reports, treatment notes, transcript of radiology reports, psychiatric or psychological records, or other documentation including medical bills, statements for medical services rendered, pertaining to the person who has signed this authorization.
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying all health care providers in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me whether or not I sign the authorization.
6. This authorization expires in two (2) years, OR upon occurrence of the following event that relates to me or to the purpose of the intended use of discloser of information about me.
7. A copy or a fax of this authorization will be valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical records.

_____

Print name of patient:

_____ _____ / _____ / _____

Signature of patient or guardian: Date:

TOTAL FUNCTION
Physical Therapy PC

Financial Agreement Form

Financial Agreement: Payment is expected at the time of service; insurance co-payments, deductible amounts, or co-insurance amounts mandated by your insurance company **MUST BE PAID AT THE TIME OF SERVICE**. As a courtesy to me, I understand that a third party billing office will be handling my claim and if requested, can provide a breakdown of what the insurance is scheduled to pay. I agree that if my insurance company denies benefits for any reason, I am responsible for the full amount of services provided. I understand that the definition of "non-covered" is made by my insurance company; I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer.

I acknowledge full financial responsibility for, and agree to pay, all charges of the clinic and of therapists rendering services as allowable per the contractual terms between my insurance company and Total Function Physical Therapy PC and not otherwise paid by my health insurance or other payer. All charges are due and payable upon receipt of the bill. If payment is not made within 90 days of the receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will be forwarded to the last address I have on file with the clinic.

I request that payment of authorized insurance / Medicare benefits be payable to Total Function Physical Therapy PC, (FEIN 75-3138902) on my behalf for services furnished to me. I authorize and direct that payment from any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the clinic. I certify that the information given by me in applying for payment under the Medicare program is correct. I request that payment of authorized benefits be made to the clinic on my behalf for the clinics and therapists charges for which the clinic is authorized to bill in connection with these health care services.

In the event that my account is turned over to a collection agency or an attorney, I agree to pay all costs of collection and I understand that I am no longer a patient at this office. I understand that any unpaid balance that is placed for collection will be subject to collection costs, reasonable attorney fees and interest at 18% per annum (1.5% per month). **I UNDERSTAND THAT SHOULD MY ACCOUNT BE TURNED OVER TO THE COLLECTION AGENCY I MUST DEAL DIRECTLY WITH THE AGENCY TO BRING MY ACCOUNT TO RESOLUTION. AT THIS POINT, TOTAL FUNCTION PHYSICAL THERAPY PC WILL NO LONGER HANDLE MY ACCOUNT.**

I understand and agree to a return check charge of $30.00 per returned check for any reason.

I understand that should a refund be owed to me by Total Function Physical Therapy PC I must be completed with care, and all dates of service need to be acknowledged and paid for by either self or insurance before refund will be issued. All refunds will be processed by Total Function Physical Therapy PC's bank and will not be a direct check.

I authorize any holder of medical information about me to release any and all information to the healthcare financing administration, its agents, or my insurance carrier as needed to determine these benefits or the benefits for myself or my dependents. If I have health insurance coverage and it is requested by my physician, I authorize Total Function Physical Therapy PC to release information concerning my diagnosis and treatment under the HIPAA privacy rule.

I understand that the clinic does not assume responsibility for the loss, damage, or disposal of my personal property or money including but not limited to jewelry, clothing, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item while I am a patient at the clinic or aquatic facility.

Consent for Healthcare Services: I voluntarily consent to and authorize the rendering of health care services, including routine clinical services, diagnostic procedures, and other services or procedures which my therapist or others holding clinical privileges consider necessary. I am aware that Physical/Aquatic Therapy treatment utilizes hands-on techniques which require the therapist to touch my body as part of the therapeutic process. I understand that health care services may be rendered by students or interns under supervision by a physical therapist. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON: Print Name:

_____ _____

RELATIONSHIP/REASON WHY PATIENT IS UNABLE TO SIGN: DATE:

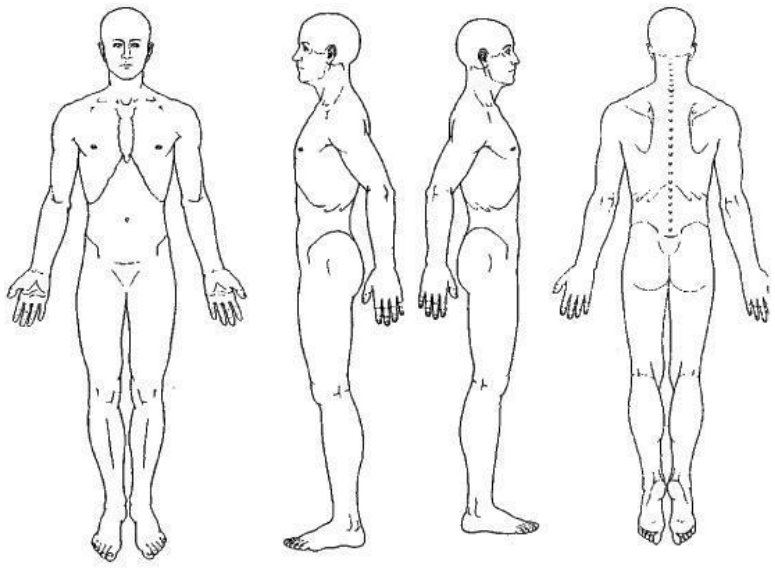
TOTAL FUNCTION
Physical Therapy PC

Patient History Form 1/3

Name: _____ **Date:** ____ /____ / 20_____

Present Condition – Pain or Symptoms

1. Please shade in area or areas where you are experiencing pain/symptoms. Then use the following descriptions of pain to indicate the type of pain in each area that you shade by drawing an arrow from each specific type of pain to the area you have shaded. Feel free to use more than one description for each shaded area.



☐ Severe	☐ Sharp	☐ Aching
☐ Moderate	☐ Dull	☐ Stabbing
☐ Numbness/tingling	☐ Burning	☐ Radiating (indicate direction)
☐ Weakness	☐ Throbbing	☐ Other _____

2. Please list each symptom that you are experiencing and rate each on a scale of 0-10 (10 being the most severe pain/symptoms you have ever experienced)

Symptoms	Severity
a._____	0 1 2 3 4 5 6 7 8 9 10
b._____	0 1 2 3 4 5 6 7 8 9 10
c._____	0 1 2 3 4 5 6 7 8 9 10

3. Since the initiation, has the pain changed?_____
4. Have your symptoms: ☐ become worse ☐ become better ☐ remained the same
5. How often do you experience the pain/symptoms?_____
6. When and what do you think initially caused your pain/symptoms? Why? _____
   _____

TOTAL FUNCTION
Physical Therapy PC

Patient History Form 2/3

Name: _____ **Date:** ____ / ____ / 20____

1. What makes your symptoms worse? ☐ Walking
   - ☐ Sitting
   - ☐ Standing
   - ☐ Bending
   - ☐ Lifting
   - ☐ Other (please specify below) _____
2. What eases your symptoms?_____
3. How much does your pain interfere with your activities?

	DAILY	EXTRA-CURRICULAR
☐ None (1-20%)	_____%	_____%
☐ Rarely (20-40%)	_____%	_____%
☐ Often (40-60%)	_____%	_____%
☐ Most of the time (60-80%)	_____%	_____%
☐ Always (80-100%)	_____%	_____%

4. Are you taking any medications? ☐Yes ☐No
   If yes, write down ALL medication you're taking. (if you have a typed up list, please provide that)
   _____

Past History of Symptoms

1. Have you ever had these kinds of symptoms before? ☐Yes ☐No
   If yes, when?_____
2. How often have they recurred?_____
3. Has the frequency or severity of these symptoms increased since the last time?
   Frequency ☐Yes ☐No Severity ☐Yes ☐No _____

Past Medical History

1. Accidents or Injuries?_____Surgeries? _____
2. Other problems that have been diagnosed by a Physician?_____
3. Are you currently under the care of a physician or other health care provider other than the one who prescribed your Physical Therapy? ☐Yes ☐No
   If yes, who?_____
4. Have you ever had Physical Therapy or body work previous to this occasion? ☐Yes ☐No
   If yes, when and how much?_____. Did it help? ☐Yes ☐No
5. What are your ***specific*** physical therapy goals you would like to achieve? _____
   _____
6. How much time in a day are you willing to commit to get better?_____

TOTAL FUNCTION
Physical Therapy PC

Patient History Form 3/3

Name: _____ **Date:** ____ /_____ / 20____

Past and Present Medical Illnesses

Please mark any of the following conditions that you have or had at one time:

- ☐ Anxiety
- ☐ Cancer
- ☐ Hepatitis
- ☐ Nervous system disease
- ☐ Stroke
- ☐ Arthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Positive HIV
- ☐ Ulcers
- ☐ Blood Clots
- ☐ Head Injury
- ☐ Kidney disease
- ☐ Seizures
- Thyroid
- ☐ Broken bones
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Skin Disease
- Other

Please explain_____

_____

_____

Review of symptoms

Please mark any of the following with which you have ever had a problem:

- ☐ Blacking out
- ☐ Change in appetite
- ☐ Difficulty breathing
- ☐ Difficulty with coordination
- ☐ Headaches
- ☐ Memory Deficits
- ☐ Numbness or Tingling
- ☐ Shortness of Breath
- ☐ Swelling

Change in Appetite

- ☐ Blurring vision
- ☐ Change in weight
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Hearing difficulty
- ☐ Muscle pain or cramps
- ☐ Paralysis
- ☐ Speech/Communication
- ☐ Tremors
- ☐ Bruise or bleed easily
- ☐ Chest pains
- ☐ Difficulty with balance
- ☐ Fatigue
- ☐ Menstrual Problems
- ☐ Muscle weakness
- ☐ Rash
- ☐ Stiffness
- ☐ Visual difficulty

Do you have a DNR (do not resuscitate) in place? ☐Yes ☐No (If yes, please provide us a copy for your file).

Equipment and devices

Please mark any of the following with which you have ever used:

- ☐ Brace
- ☐ Dentures
- ☐ Pacemaker
- ☐ Cane
- ☐ Glasses or contacts
- ☐ Walker
- ☐ Crutches
- ☐ Hearing aid

For women only

1. Are you pregnant? ☐Yes ☐No
2. Do you have a regular, normal menstrual cycle? ☐Yes ☐No
3. Do you have considerable pain or discomfort during your period? ☐Yes ☐ No