For Life Therapy Inc

PATIENT INTAKE FORM

Patient Information

Legal Name:_______________________________________ ☐ M ☐ F Preferred Name:_____________________
Date of Birth: __________/__________/__________ Social Security Number:__________-________-_____________
Address: ____
City: ____ State: __________ Zip: _________________
Primary Phone Number: (_______)__________-____________ ☐ Home ☐ Cell ☐ Work

Appointment Reminders: ☐ Called ☐ Texted: Cell phone company required: _____________________
(Message and data rates may apply.)

Other Phone Number: (_______)__________-____________ ☐ Home ☐ Cell ☐ Work
Email: ____ ☐ I accept e-mails related to For Life Therapy Inc.

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Separated
Employer/ School/Retired:____
Name of Primary Doctor:________________________ Name of Primary Clinic:______________________________
Whom may we thank for referring you? ____

Emergency Contact

Person to contact in case of emergency:____
Phone: (_______)__________-____________ Relationship to Patient:_________________________________

Primary Insured on Policy
(if different than patient)

Name of Insured : ____________________________________ Relationship to Patient: ________________________
Date of Birth: _____/_____/__________ Social Security Number:__________-__________-____________

If different than above patient's:

Address: ____
City: ______________________________ State: __________ Zip: _____________ Phone: (_____) ______-_________

Responsible Party for Billing
(if different than patient)

Name: ____ Relationship to Patient: ________________________
Address: ____
City: ______________________________ State: __________ Zip: _____________ Phone: (_____) _______-_________

Patient: _________________________________ ___/___/___

For Life Therapy Inc

PAYMENT POLICY

INSURANCE

- We must obtain a copy of your current valid health insurance card at your first visit to provide proof of insurance.
- If your insurance changes, it is your responsibility to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.
- We reserve the right to refuse service if current health insurance information is not provided.
- Your insurance coverage and benefits are a contract between **you and your insurance company**, in which **you** agree to pay any copays, deductibles and/or co-insurance to service providers before insurance will pay benefits on your behalf.
- We make an effort to notify you of your insurance benefits for physical therapy; however, it is **your** responsibility to know and understand your full insurance benefits and what services your policy will or will not cover.
- Not all insurance policies cover all services that may be provided to you; You are responsible for paying for any services provided to you that your insurance policy does not cover.
- We will submit your claims to insurance and assist you in any reasonable way to help get your claims paid.

PAYMENTS

- Co-pays are due at time of service.
- A $25.00 payment is due at the time of service if you have not met your insurance deductible or out-of-pocket maximum (and you do not have a co-pay.) This payment will be applied to your balance due for deductible or out-of-pocket maximum/co-insurance.
- We reserve the right to refuse service if payments are not made at the time of service.
- We reserve the right to refuse future services until outstanding/overdue balances are paid.
- Payments can be made with:
    - Cash
    - Check
    - Money Order
    - Visa, MasterCard, Discover, American Express Credit/Debit cards

- Partial payments will not be accepted unless otherwise negotiated.

NONPAYMENT AND COLLECTIONS

- If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full.
- Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.
- Balances not paid as explained above will be turned over to collections.
- $40 fee for all accounts turned over to collections.

RETURNED CHECKS

- $40 fee for all returned checks.

MISSED APPOINTMENTS

- Please call at least 24 hours in advance to reschedule your appointment if needed.
- After missing three appointments, you will be discharged from physical therapy.
- You may be responsible for payment of your missed appointments.

Version 6/11/2018

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.   Please let us know if you have any questions or concerns.

Patient: ______________________________   ___/___/___

For Life Therapy Inc

CASE AUTHORIZATION FORM

Problem Area: ______________________________________ **Problem Onset Date:** _____/_____/_____

INITIAL	POLICY
________	**Authorization for Treatment** • I hereby give authorization for the performance of such rehabilitation procedures as permitted by South Dakota Statutes under the appropriate scope of practice are, in the judgment of my Physical Therapist, deemed necessary.
________	**HIPAA: Health Insurance Portability and Accountability Act** • I have been offered a copy of "Notice of Privacy Practices" mandated by HIPAA.
________	**Payment Policy** • I have received a copy of *For Life Therapy Inc*'s Payment Policy (version 6/11/2018) and I agree to abide by it's guidelines. I agree to pay *For Life Therapy Inc* charges for services rendered to me. I agree to pay those charges which may not be paid by my health insurance, including deductible, copay, coinsurance, etc., and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay *For Life Therapy Inc* collections costs incurred including attorney and court fees.
________	**Information Provided** • The information I have provided is true and accurate, and I agree to immediately provide *For Life Therapy Inc* with any changes to this information, both during and following my course of treatment.
________ **No Yes**	**Chiropractic Services** • I agree that I have been informed that most insurances do not allow Chiropractic services and Physical Therapy services to be billed on the same day. I agree that I will not schedule or attend any Chiropractic appointments on the same day as my Physical Therapy appointments with *For Life Therapy Inc*. I agree to pay for any denied services provided by *For Life Therapy Inc* in the event that I attend a Chiropractic appointment on the same date of service. Are you currently receiving Chiropractic care for any reason?
No Yes ________	**Information Sharing** • I hereby authorize For Life Therapy to discuss my health information with my first relatives (i.e. spouses, parents, children, and siblings) or emergency contact. I understand that this authorization is voluntary and may change my mind at any time.
 No Yes **No Yes** **No Yes**	**Workers Compensation or Motor Vehicle Accident** I am seeking services as the result of a work related injury or motor vehicle accident. I have already filed a claim with Workers' Compensation or an Auto Insurance Company. I am considering filing a claim for Workers' Compensation or a Motor Vehicle Accident.
Have you received Physical Therapy treatment at any other location within this year, including at a clinic, private practice clinic, hospital out-patient therapy, post-surgical checkups, etc? (NOT including in-patient hospital therapy) **No Yes**	Approximate number of visits:_____________ Location: _____________________________________

____ ____ ___/___/___

Printed Patient Name Signature of Patient/Legal Guardian/POA Date

Case # _____ Patient: _________________________________ ___/___/___

For Life Therapy Inc

MEDICAL HISTORY

Have you/family ever had:	FAMILY	YOU
Cancer	Yes No	Yes No
Diabetes	Yes No	Yes No
High Blood Pressure	Yes No	Yes No
Heart Disease	Yes No	Yes No
Angina/Chest Pain	Yes No	Yes No
Osteoporosis (thinning bone)	Yes No	Yes No
Osteoarthritis (arthritis)	Yes No	Yes No
Rheumatoid Arthritis	Yes No	Yes No

In the past 3 months have you experienced:	
A change in your health	Yes No
Nausea/vomiting	Yes No
Fever/chills/sweats	Yes No
Unexplained weight change (loss or gain)	Yes No
Numbness or tingling	Yes No
Changes in appetite	Yes No
Difficulty swallowing	Yes No
Changes in bowel or bladder function	Yes No
Shortness of breath	Yes No
Dizziness	Yes No
Upper respiratory infection	Yes No
Urinary tract infection	Yes No

Other:____
____

Any other symptoms, conditions, or health concerns:
____
____

Current Medications: ____________________________
____
____

Do you have a history of:	YOU
Allergies (seasonal, medications, latex, etc.) Yes: ______________________________	Yes No
Asthma	Yes No
Headaches	Yes No
Bronchitis	Yes No
Kidney Disease	Yes No
Rheumatic Fever	Yes No
Pacemaker	Yes No
Medical Implant: ____________________	Yes No
Sexually transmitted disease	Yes No
Seizures	Yes No
Depression	Yes No
Anxiety	Yes No

Are you currently:	
Pregnant	Yes No
Under significant stress	Yes No

Are your symptoms
☐ Getting worse ☐ About the same ☐ Improving

How do you sleep at night?
☐ Fine ☐ With difficulty ☐ With Medication

Do you have trouble with
☐ Hearing ☐ Speech/Communication ☐ Vision

Do you or have you ever used tobacco:
☐ Yes: how much/often ________________________
☐ No ☐ Quit ______________ ago

Do you or have you consumed alcoholic beverages:
☐ Yes: how much/often ________________________
☐ No ☐ Quit ______________ ago

Date of Last Physical Examination: _____/_____/_____

Patient: ________________________________ ___/___/___