

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: (____) _____ - _____

Workers Compensation or Motor Vehicle Accident

- Yes No I am seeking services as the result of a work related injury or motor vehicle accident.
 Yes No I have already filed a claim with Workers' Compensation or an Auto Insurance Company.
 Yes No 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)

Yes No Approximate number of visits: _____ Location: _____

Yes No Are you receiving Chiropractic care for any reason? **NOTE:** Physical Therapy and Chiropractic appointments **cannot** be attended on the **same day**.

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 <ul style="list-style-type: none">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 <ul style="list-style-type: none">I have been offered a copy of "Notice of Privacy Practices" mandated by HIPAA.
_____	Payment Policy <ul style="list-style-type: none">I have received a copy of <i>For Life Therapy Inc's</i> Payment Policy (version 6/11/2018) and I agree to abide by it's guidelines. I agree to pay <i>For Life Therapy Inc</i> 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 <i>For Life Therapy Inc</i> collections costs incurred including attorney and court fees.
_____	Information Provided <ul style="list-style-type: none">The information I have provided is true and accurate, and I agree to immediately provide <i>For Life Therapy Inc</i> with any changes to this information, both during and following my course of treatment.
_____	Chiropractic Services <ul style="list-style-type: none">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 <i>For Life Therapy Inc</i>. I agree to pay for any denied services provided by <i>For Life Therapy Inc</i> in the event that I attend a Chiropractic appointment on the same date of service.
Yes No _____	Information Sharing <ul style="list-style-type: none">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.

Printed Patient Name

Signature of Patient/Legal Guardian/Representative/POA

Date

Case # _____

Patient: _____/____/____

For Life Therapy Inc

MEDICAL HISTORY

Have you/family ever had:	FAMILY	YOU	Do you have a history of:	YOU
Cancer	Yes No	Yes No	Allergies (seasonal, medications, latex, etc.) Yes: _____	Yes No
Diabetes	Yes No	Yes No	Asthma	Yes No
High Blood Pressure	Yes No	Yes No	Headaches	Yes No
Heart Disease	Yes No	Yes No	Bronchitis	Yes No
Angina/Chest Pain	Yes No	Yes No	Kidney Disease	Yes No
Osteoporosis (thinning bone)	Yes No	Yes No	Rheumatic Fever	Yes No
Osteoarthritis (arthritis)	Yes No	Yes No	Pacemaker	Yes No
Rheumatoid Arthritis	Yes No	Yes No	Medical Implant: _____	Yes No
In the past 3 months have you experienced:			Sexually transmitted disease	Yes No
A change in your health		Yes No	Seizures	Yes No
Nausea/vomiting		Yes No	Depression	Yes No
Fever/chills/sweats		Yes No	Anxiety	Yes No
Unexplained weight change (loss or gain)		Yes No	Are you currently:	
Numbness or tingling		Yes No	Pregnant	Yes No
Changes in appetite		Yes No	Under significant stress	Yes No
Difficulty swallowing		Yes No	Are your symptoms <input type="checkbox"/> Getting worse <input type="checkbox"/> About the same <input type="checkbox"/> Improving	
Changes in bowel or bladder function		Yes No	How do you sleep at night? <input type="checkbox"/> Fine <input type="checkbox"/> With difficulty <input type="checkbox"/> With Medication	
Shortness of breath		Yes No	Do you have trouble with <input type="checkbox"/> Hearing <input type="checkbox"/> Speech/Communication <input type="checkbox"/> Vision	
Dizziness		Yes No	Do you or have you ever used tobacco: <input type="checkbox"/> Yes: how much/often _____ ago <input type="checkbox"/> No <input type="checkbox"/> Quit _____ ago	
Upper respiratory infection		Yes No	Do you or have you consumed alcoholic beverages: <input type="checkbox"/> Yes: how much/often _____ ago <input type="checkbox"/> No <input type="checkbox"/> Quit _____ ago	
Urinary tract infection		Yes No	Date of Last Physical Examination: ____/____/____	
Other: _____ _____				
Any other symptoms, conditions, or health concerns: _____ _____				
Current Medications: _____ _____ _____				

Patient: _____/____/____