FALCON PHYSICAL THERAPY

Patient Intake Form

Today's Date:_____

HAVE YOU BEEN SEEN IN ANY OF OUR CLINICS BEFORE? ❒No ❒Yes When?_____ ____

Full Legal Name_____

Date of Birth_____ Age_____ ❒Married ❒Single ❒Other ❒Male ❒Female

Address_____
Street **City** **State** **Zip Code**

Patient's Social Sec. #_____–_____–_____ E-mail:_____

Home Phone( ) _____ May we leave message? ❒ Yes ❒ No

Cell Phone ( )_____ Voice message? ❒ Yes ❒ No Text message? ❒ Yes ❒ No

Work Phone ( ) _____ May we leave message? ❒ Yes ❒ No

- **RESPONSIBLE PARTY:** Full name_____
- Relationship_____ Social Sec. #_____–_____–_____ Date of Birth_____
- Address (if different) _____

Employer_____ Phone ( ) _____

Attorney_____ Phone ( ) _____

PLEASE CIRCLE ONE: WORK COMP AUTO PRIVATE/HEATH SELF PAY

Primary Insurance Co_____ Phone ( ) _____

Address_____

Case Manager/Adjuster_____ Phone ( )_____Ext_____

ID or Claim #_____ Group # _____ Date of Injury _____

Insured's Name/Relationship_____ Date of Birth_____

Secondary Insurance Co_____ Phone ( ) _____

Insured's ID #_____ Group #_____

Insured's Name/Relationship_____ Date of Birth_____

Tertiary Insurance_____ Insured's Name/Relationship_____

ID# _____ Group #_____

Referring Physician _____ Phone ( )_____

Diagnosis or Area to be Treated_____ICD-9/10Code_____

Initial Eval Scheduled: _____

Email_____ WebPT_____ VOB List_____

_____
Staff Initials

Patient Review: _____/_____ _____/_____ _____/_____
Initials / Date Initials / Date Initials / Date

Falcon

Physical Therapy

Consent for Treatment

I, the undersigned, a patient of Falcon Physical Therapy and Fitness, LLC, do hereby authorize Falcon Physical Therapy and Fitness, LLC personnel to administer treatment as is necessary to treat my condition.

I understand that as a patient I have the right to make informed decisions regarding my plan of care, and that I have the right to further advice, if necessary, to help me make decisions. I have the right to refuse medical care and to know the possible results of refusing the treatment and care offered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy, Falcon Physical Therapy and Fitness, LLC will prepare insurance forms and bill my insurance company utilizing the services of Integrity Billing. I hereby request assignment of all insurance benefits to Falcon Physical Therapy and Fitness, LLC.

I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. I also understand that I am responsible for paying my co-pay at the time of service unless prior arrangements have been made with Falcon Physical Therapy and Fitness, LLC. In addition, I understand that I am responsible for my deductible.

Cancellation/ No-Show Policy

I understand and agree that canceling physical therapy appointments hurts three people:
1) Me: because I do not receive treatment that could influence my recovery
2) My Therapist: because they lose time that they could use to treat someone else.
3) Other Patients: because they may have been able to be seen in that time slot.

I agree that all cancellations **must be made 24 hours prior to the scheduled appointment time,** I also understand that Falcon Physical Therapy will charge **$40** for non-compliance to this policy, ***unless I reschedule within the same week***. I am aware that these charges will be directly billed to me and that I am responsible for these charges.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Legal Guardian Date

Falcon

Physical Therapy

Release of Patient Information Consent Form

___ My Physician(s): Dr. _____

___ My Spouse/Significant Other: _____

___ My Lawyer: _____

___ Other: _____

Reason for Release: Medical Records and Medical Treatment

Please Initial:

_____ **ALL:** I hereby authorized Falcon Physical Therapy and Fitness, LLC to provide the above named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

_____**SOME: :** I hereby authorized Falcon Physical Therapy and Fitness, LLC to provide the above named individual or company with specific elements of my medical data and information as designated below, concerning my illness or injury.

_____ **NONE: :** I hereby refuse Falcon Physical Therapy and Fitness, LLC to provide the above named individual or company with medical data and information concerning my illness or injury.

Medical Data/Information

(Please check all that are approved to be released to the above individuals)

_____ Name, address, phone number
_____ Social Security number
_____ Date(s) of visit(s)
_____ Diagnosis
_____ Findings of initial examination
_____ Daily handwritten office notes
_____ Exercise logs
_____ Exercise instruction sheets
_____ Progress Summaries
_____ Discharge Summary
_____ Correspondence to other health care providers

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Original to be placed in patient's medical record

Falcon

Physical Therapy

Release for Phone Contact

HIPPA requires all health care practitioners to obtain permission on locations where they may contact you/leave a message. By filling out this form, you give us permission to call or leave a message at the following locations/numbers:

Home: (_____) _____	OK to leave a message?	YES	NO
Work: (_____) _____	OK to leave a message?	YES	NO
Cell: (_____) _____	Ok to leave a message?	YES	NO
Other: (_____) _____			
Name(s): _____	Ok to leave a message?	YES	NO

Protected Health Information Verification

I, the undersigned, have read and understand Falcon Physical Therapy and Fitness, LLC's "Privacy Notice". I also understand that unauthorized use or disclosure of my information shall be reported to Falcon Physical Therapy and Fitness, LLC's privacy officer who will conduct an investigation that will result in disciplinary action up to and including termination of employment/contract/association and the imposition of fines pursuant to applicable state and federal laws.

_____

Patient Signature Date

_____

Signature of Staff Date

Falcon

Physical Therapy

Medication List

Please list all medications/over-the-counter medications/vitamins/mineral/dietary supplements with dosages.

Medication	Dosage	Frequency	Route of Administration
Example: Ibuprofen	*2 pills,50mg*	*4xday/ 2hours*	*Oral*

Falcon

Physical Therapy

Medical Intake

Name:_____ Birthdate:_____

Referring Physician:_____ Primary Care Physician:_____

Current Injury/Illness

Diagnosis:_____ Date of Injury:_____

Please list your primary reason(s) for seeking medical attention at this time:
1._____ 2._____
3._____ 4._____
Have you had any recent diagnostic tests? X-ray MRI Lab CT Scan Other:_____
How did this injury occur? _____
Have you had this problem before? YES/NO Are you currently under chiropractic care? YES/NO
If yes, Chiropractor's name? _____How often do you receive treatment? _____

Please **circle** any of the following medical diagnoses that you **currently** have.

Heart Disease	Broken Bones	Sprain	Strain	High Blood Pressure
Heart Attack	Cancer	Ulcers	Depression	Anxiety
Stroke	Arthritis	Osteoporosis	Back Pain	Infection
Fibromyalgia	Headaches	Nausea/Vomiting	Chest Pain	Asthma
Traumatic Brain Injury		Psychological Disorder		Pregnancy
Diabetes	Other:_____			

Please list your goals for attending Physical Therapy:
1._____ 2. _____
3. _____ 4. _____

Medical History

Have you ever had physical therapy before? Yes No
Why? _____
Have you **ever** had any of the following? (Please circle all that apply)

Heart Disease	Broken Bones	Sprain	Strain	High Blood Pressure
Heart Attack	Cancer	Ulcers	Depression	Anxiety
Stroke	Arthritis	Osteoporosis	Back Pain	Infection
Fibromyalgia	Headaches	Nausea/Vomiting	Chest Pain	Asthma
Traumatic Brain Injury		Psychological Disorder		Pregnancy
Diabetes	Other:_____			

Have you had any surgeries? Yes/No
If so, please list (including date(s)): _____
_____