Patient Intake Form

203 East Baltimore Pike
Media, PA 19063 • (610)565-0670

Date of Evaluation: _____ *Your Therapist:* _____

Patient Information

First Name: _____ *Last Name:* _____ *Middle:* _____

Street Address: _____

City: _____ *State:* _____ *Zip:* _____

Home Phone: _____ *Cell/Alternate Phone:* _____

Date of Birth: _____ *E mail:* _____

Insurance Carrier: _____ *Insurance ID#:* _____

Date of Injury/Accident/Surgery _____ *Emergency Contact:* _____
Phone: _____

If you are seeking Physical Therapy due to an accident or work-related injury, please provide the following:

Claim #: _____ *Adjuster:* _____

Insurance Company: _____ *Contact Phone #:* _____

Physician Information

Referring Physician _____ *Primary Care* _____

Office Location (RP) _____ *Office Location (PC)* _____

Phone: _____ *Phone:* _____

General Information

What type of pain or ailment is causing you to seek physical therapy? _____

Have you had prior therapy treatment this year? *Y* *N* *If yes, location* _____

How did you hear about Restoration Physical Therapy? _____

What are your goals for rehabilitation? _____

Patient Financial Policy

Patient agrees to pay for all portions of services due in full at the time services are provided. Any outstanding balances, co-payments and deductibles are due at the time of service.

***Commercial Insurance Carriers**: We bill most insurance carriers on your behalf. Your agreement with your insurance carrier is a private one. Typically there is a co-payment or annual deductible associated with a commercial insurance plan. As a courtesy to you, we will attempt to contact your insurance company and verify your benefit details. Your insurance carrier will inform us of your plans benefit details, however they are subject to change and sometimes reported to us inaccurately. It is the patients' responsibility to verify and understand their financial obligation. If an insurance carrier deems these services to be not medically necessary, you will be responsible for payment at a rate of $75 per visit. If an insurance carrier has not paid within 45 days of the date of service, any charges are due and payable in full from.*

***Medicare**: Our office is a Medicare participating provider and we will bill Medicare for you. We will also bill secondary insurances that automatically crossover through the Medicare System (CMS). If your secondary insurance does not automatically crossover you will be responsible for any coinsurance and non-covered service that Medicare does not reimburse.*

***Worker's Compensation and Automotive Claims:** If your visit is work related or the result of an automotive claim there will be no out of pocket expense provided we have received the claim number, adjuster, and carrier information prior to your visit.*

***Cancellations**: There is a twenty five dollar ($25.00) fee for "no shows" and cancellations of appointments without providing twenty-four (24) hours notice.*

I have read, understood and agreed to the above financial policy for payment of professional fees.

Patient Signature: _____ *Date:* _____

Patient Consent and Release of Information

I understand that as part of my healthcare, Restoration Physical Therapy originates and maintains paper and electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I give consent to Restoration Physical Therapy to release to the appropriate agencies any information acquired through the course of my evaluation examination and treatment. I understand and have been provided a Notice of Privacy Practices that provides a more complete description of how my medical information is used and disclosed. I further authorize employees of Restoration Physical Therapy to perform the appropriate evaluation and treatment procedures relating to the condition(s) for which therapy is sought.

I have read, understood and agreed to the terms of consent and release of information.

Patient Signature: _____ *Date:* _____

Medical History Questionnaire

Please describe any significant injuries or surgeries for which you have been treated and/or hospitalized and the approximate date of injury or hospitalization:

Date	Injury or reason for Surgery

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following:

Y	N	Diabetes	Y	N	Kidney Disease	Y	N	Epilepsy
Y	N	Tuberculosis	Y	N	Cancer	Y	N	Dependency
Y	N	Heart Disease	Y	N	Arthritis	Y	N	Mental Illness
Y	N	High Blood Pressure	Y	N	Anemia	Y	N	Alcoholism/Chemical
Y	N	Stroke	Y	N	Headaches	Y	N	Other

Which of the following OVER THE COUNTER medications have you taken in the last week?

Y	N	Aspirin	Y	N	Weight Gain/Loss
Y	N	Tylenol	Y	N	Nausea/Vomiting
Y	N	Advil/Motrin/Ibuprofen	Y	N	Fatigue
Y	N	Laxatives	Y	N	Weakness
Y	N	Decongestants	Y	N	Fever/Chill/Sweats
Y	N	Antihistamines	Y	N	Numbness or Tingling
Y	N	Vitamins/Mineral supplements	Y	N	Bowel/Bladder Problem
Y	N	Other			

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

*1.*_____ *2.*_____ *3.* _____

How many caffeinated beverages do you drink per day? ___ *How many cigarettes do you smoke per day?* ___
How many days per week do you drink alcohol? _____ *Are you latex sensitive: Yes / No*
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____
List any allergies including medications that we should know about

_____

Have you EVER been diagnosed as having any of the following conditions?

Y	N	Cancer	Y	N	Other arthritic conditions
Y	N	Heart Problems	Y	N	Depression
Y	N	High Blood Pressure	Y	N	Hepatitis
Y	N	Circulation Problems	Y	N	Tuberculosis
Y	N	Kidney Problems	Y	N	Stroke
Y	N	Nervous Disorders	Y	N	Kidney Disease
Y	N	Asthma	Y	N	Anemia
Y	N	Emphysema/Bronchitis	Y	N	Epilepsy
Y	N	Chemical Dependency	Y	N	Osteoporosis or Osteopenia
Y	N	Thyroid Problem	Y	N	Diabetes
Y	N	Rheumatoid Arthritis	Y	N	Multiple Sclerosis
Y	N	Other			

Patient Signature: _____ ***Date:*** _____