



PATIENT INTAKE FORM (1/2)

Patient Information	Date: _____ Patient Name: _____
	DOB: _____ Gender at Birth: M F Preferred Pronouns: _____
	Parent/Guardian Name: _____ Relationship to Patient: _____
	Mailing Address: _____
	City: _____ State: _____ Zip: _____ Home Phone: _____
	Cell Phone: _____ Email: _____
	Preferred method of contact for appointment reminders: <input type="radio"/> Text <input type="radio"/> Email <input type="radio"/> Please do not contact
	Do we have permission to leave a voice message? <input type="radio"/> Yes <input type="radio"/> No Other: _____
Under 18: Y N If yes, Parent/Guardian Name: _____ DOB: _____	

Insurance Type Personal Workers Compensation Claim Motor Vehicle Accident

Add'l Info.	How did you hear about us? (ie. MD, online, friend, etc..) _____
	PCP: _____ Practice Name: _____ Phone: _____
	Date of Onset: _____ (if applicable) Date of next MD Appt: _____
	Is this an Auto Accident injury? <input type="radio"/> Yes <input type="radio"/> No

Insurance Information **: Primary: _____ Secondary: _____
 **see verification & estimated responsibility for more detailed information

Consent to Treat	<i>I, the undersigned, give Bay State Physical Therapy and its affiliates* my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, my condition may worsen or new symptoms may develop on rare occasions. I also understand that no guarantee or promise has been made to me concerning the results of treatment. Lastly, I understand that common areas are accessed by other patients, gym members and guests and as a result, there may be incidental contact with personal health information.</i>
	Signature: _____ Date: _____ Relationship to patient: _____

No Shows/Cancellation Policy	<i>In order for you to have the best possible outcome from your treatment, it is essential that you attend all of your appointments. To that effort, we schedule our patients for one-on one treatment times. Missing scheduled appointments greatly hinders progress toward your goals and may result in delaying your recovery. We respectfully require a 24 hour notice for any appointment cancellation which allows us the best opportunity to accomodate another patient requiring treatment. We reserve the right to charge a missed visit fee if less than 24 hours notice is given. Exceptions would be emergency, illness or inclement weather.</i>
	DO NOT CANCEL if you are feeling worse or believe the treatment is not working. Please understand that your pain will fluctuate as your course of treatment progresses. Keep your appointment and discuss any changes with your PT or DC.
	DO NOT CANCEL if you are feeling better; keep your appointment in order to progress your plan of care & prepare for discharge.
	Signature: _____ Date: _____ Relationship to patient: _____

PATIENT INTAKE FORM (2/2)

Ack of Notice of Privacy Practices & Release of Information

I, the undersigned, have read & understand the Notice of Privacy Practices. Bay State Physical Therapy & its affiliates* reserve the right to modify the privacy outlined in this notice.

Signature: _____ Date: _____ Relationship to patient: _____

I understand that Bay State Physical Therapy and its affiliates* may use or disclose my Personal Health Information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments. I further understand I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy and its affiliates* will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby authorize one or all of the designated parties listed below to request and receive the release of any PHI regarding my treatment, payment or administrative operations related to my treatment and payment. I also understand that the identity of the designated parties must be verified before the release of any information.

Please provide the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Individual: _____ Phone & Relationship: _____

Authorized Individual: _____ Phone & Relationship: _____

Patient Name: _____ Date: _____ DOB: _____

Signature: _____ if under 18 Relationship to patient: _____

Financial Policy

As a service to our patients, we will verify your benefits with your insurance company. It is, however, **the patient's responsibility to be aware of their in-network/out of network options as well as the contractual agreement they have with their insurance company per their policy. It is the patient's responsibility to initiate a referral when it is required.**

Patients MUST immediately report to us any changes to their insurance plans. Any denials in services already provided as a result of failing to report changes will be the financial responsibility of the patient. Although we make every effort to assist our patients in dealing with their insurance companies, we cannot serve as negotiators of the contract between these two parties. Ultimately, it is the patient's responsibility to resolve any insurance denials directly with their insurance company when the denial is through no fault of our practice.

I understand and agree that insurance claim forms will be submitted to my insurance company on my behalf as a matter of convenience only and that I am responsible for all charges regardless of my existing medical coverage. I also understand that I am responsible for any out of pocket costs such as copays, deductibles, coinsurances & medical supplies. I also understand that **copays are due at the time services are rendered** & any medical supplies must be paid for the same day.

I hereby give authorization for payment of insurance benefits to be made directly to Bay State Physical Therapy & its affiliates* for services rendered. In the event that my insurance company forwards payment directly to me, I will immediately deliver said payment to the clinic where services were rendered.

I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I further understand that by not addressing my balance beyond the second billing cycle may subject my account to collections actions. I understand and agree that if it becomes necessary for Bay State Physical Therapy and it's affiliates to utilize an outside collection agency or to commence court action for the collection of any outstanding charges, I will be responsible for the outstanding balance as well as attorney fees, court costs and any other related expenses.

I agree to release of medical or other information necessary to process my claim.

I understand that any unsettled balances from a previous case must be resolved prior to returning for care.

Returned Check Policy: Any checks returned for insufficient funds will immediately be subject to a \$30 processing fee in addition to the value of the check. Patients with a returned check fee will not be permitted to use this form of payment going forward for product or services.

Person Responsible for Charges: _____
please print signature date

* Bay State, Cypress, MCR, MVPT

MEDICAL HISTORY FORM

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

Have you ever been diagnosed and/or treated for any of the following conditions (Mark all that apply):

- | | | | |
|--|--|--|--|
| CONSTITUTIONAL
<input type="radio"/> Weight Loss
<input type="radio"/> Fatigue
<input type="radio"/> Fever | PSYCHIATRIC
<input type="radio"/> Anxiety
<input type="radio"/> Depression
<input type="radio"/> Other: _____ | GASTROINTESTINAL
<input type="radio"/> Heartburn/Reflux
<input type="radio"/> Nausea/Vomiting
<input type="radio"/> Diarrhea/Constipation
<input type="radio"/> Change Bowel Mvts
<input type="radio"/> Abdomial Pain
<input type="radio"/> IBS | NEUROLOGICAL
<input type="radio"/> Stroke/CVA
<input type="radio"/> Headaches
<input type="radio"/> Tremors
<input type="radio"/> Memory Loss/Dementia
<input type="radio"/> Epilepsy/Seizures
<input type="radio"/> Parkinson's Disease
<input type="radio"/> Numbness/Neuropathy |
| VISION/HEARING
<input type="radio"/> Glasses/Contacts
<input type="radio"/> Cataracts
<input type="radio"/> Double Vision
<input type="radio"/> Hearing Loss | RESPIRATORY
<input type="radio"/> Cough
<input type="radio"/> Asthma
<input type="radio"/> Shortness of Breath
<input type="radio"/> COPD | GENITOURINARY
<input type="radio"/> Burning/Frequency
<input type="radio"/> Leakage
<input type="radio"/> Blood in Urine
<input type="radio"/> Erectile Dysfunction | MUSCLE/BONE
<input type="radio"/> Joint Pain/Swelling
<input type="radio"/> Stiffness
<input type="radio"/> Muscle Pain
<input type="radio"/> Bone Pain
<input type="radio"/> OA |
| CARDIOVASCULAR
<input type="radio"/> Murmur
<input type="radio"/> Chest Pain
<input type="radio"/> Palpitations
<input type="radio"/> High/Low Blood Pressure
<input type="radio"/> High Cholesterol
<input type="radio"/> Swelling in Ankles
<input type="radio"/> Heart Attack/MI
<input type="radio"/> Pacemaker/Defibrillator | ENDOCRINE
<input type="radio"/> Diabetes Type 1 or 2
<input type="radio"/> Hyper/Hypothyroid
<input type="radio"/> Kidney problems
<input type="radio"/> Loss of Hair | AUTOIMMUNE
<input type="radio"/> Lupus
<input type="radio"/> RA
<input type="radio"/> Psoriasis
<input type="radio"/> HIV/AIDS
<input type="radio"/> Fibromyalgia | CANCER
<input type="radio"/> Date of Diagnosis: _____
<input type="radio"/> Type/Location: _____
<input type="radio"/> Status: _____ |
| SKIN
<input type="radio"/> Rashes/Sores/Lesions
<input type="radio"/> Itching/Burning | | | |

Medical History

Describe any other conditions or precautions: _____

Please list any allergies that you have (i.e.; medications, latex, food, bee stings): _____

Injured as a result of a fall in the past year? Y N If yes, list date of fall: _____

Have you had two or more falls in the past year? Y N If yes, list dates of falls: _____

Surgical History

Please list past surgeries/procedures/hospitalizations: Check to signify separate list attached.

	Date: _____
	Date: _____
	Date: _____
	Date: _____

Current Rx

Please list all medications, dosage, frequency and route : Check to signify separate list attached.

Name: _____	Dosage: _____	Frequency: _____	Route: _____
Name: _____	Dosage: _____	Frequency: _____	Route: _____
Name: _____	Dosage: _____	Frequency: _____	Route: _____
Name: _____	Dosage: _____	Frequency: _____	Route: _____

Any additional information: _____

PRESENT CONDITION

Name: _____ DOB: _____ Date of Injury/Onset: _____

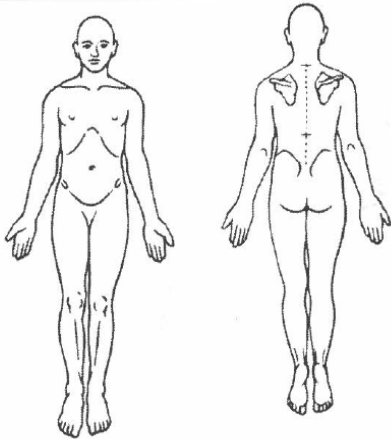
What are you seeing our PT or DC for today? _____

Have you been seen by a PT or DC for this condition? Y N *If yes, # of visits:* _____

Have you received outpatient or home care within this calendar year for any reason? Y N *If yes, # of visits:* _____

if applicable: Company/Contact Name: _____ Date of D/C: _____ PH: _____

Please localize your pain or abnormal symptoms/sensations by marking on the body diagram below.



Condition 1: _____

Pain at best: 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Pain at worst: 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Condition 2: _____

Pain at best: 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Pain at worst: 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Nature of pain/symptoms: (check all that apply)

- sharp
- dull
- burning
- other: _____
- aching
- throbbing
- shooting

Have you experienced similar symptoms in the past?

- yes
- no

More than one episode? yes no

Any additional information: _____

Was the onset of this episode:

- gradual
- sudden

Since the onset of your condition, are your symptoms:

- getting better
- worse
- same

Your symptoms are worse in the:

- morning
- afternoon
- night
- increased during the day
- same all day

What aggravates your symptoms? (check all that apply)

- sitting
- going to/rising from sitting
- lying down
- walking
- reaching overhead
- reaching in front of body
- reaching behind back
- reaching across body
- household activities
- repetitive activities
- other: _____
- standing
- squatting
- sleeping
- up/down stairs
- coughing/sneezing
- taking a deep breath
- looking up overhead
- sustained bending
- recreations or sports
- stress

What eases your symptoms? (check all that apply)

- cold
- heat
- massage
- rest
- other: _____
- stretching
- exercise
- sitting
- standing
- lying down
- nothing
- medication

Does the pain wake you at night? yes no

How would you rate your general health?

- Excellent
- Good
- Average
- Fair
- Poor

Living situation: live alone live with family

- live with caregiver
- assisted living

Home Setting:

- no stairs
- elevator
- stairs (railing)
- ramp
- stairs (no railing)
- uneven ground

Signature: _____ Date: _____ Relation to Patient if under 18: _____