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PHYSICAL THERAPY
Where Mind, Body & Soul Connect

Intake Form- Patient Information

First Name: _____MI: ___ Today's Date: _____

Last Name: _____ Date of Injury/ Onset: _____

Address: _____ Date of Birth: _____Age: _____

City: _____State: ___Zip: _____ Sex: ☐M ☐F Height: _____Weight: _____

Responsible Party Name and Relationship (for minors): _____

Address (if different from above): _____

Employer: _____ Occupation: _____

Primary Care Physician: _____Physician Number: _____

Reason for Visit: _____

How did you hear about us? _____

Contact Information

☐Phone:(cell) ☐Email

_____ _____

I certify that all the information provided herein is true and correct.

Patient/ Guardian Signature: _____ Date: _____

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CONSENT TO PHYSICAL THERAPY
(Please read and sign below)

1. CONSENT TO TREATMENT: I consent to rehabilitation and related services at Missing Link Physical Therapy. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.
2. TREATMENT OF MINORS: I, as parent/ guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.!
3. LIABILITY: I know and agree that Missing Link Physical Therapy is not responsible for loss or damage to personal valuables.
4. WAIVER and RELEASE: I hereby release, discharge and acquit Missing Link Physical Therapy, its agents, representatives, affiliates, employees, or assigns, of all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service Emergency Medical Technician, physician or urgent care services.
5. AUTHORIZATION OF PAYMENT: I consent that I will provide full payment to Missing Link Physical Therapy on services provided on that day of service.

I certify that all the information provided herein is true and correct.

Patient/ Guardian Signature: _____ Date: _____

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RELEASE OF HEALTH INFORMATION

I give permission to Missing Link Physical Therapy to release information, verbal and written, from my medical records to my physician, insurance company, case manager, attorney, school, related healthcare provider, or other agencies as it relates to my treatment. I further authorize Missing Link Physical Therapy to obtain medical records from my physician or other medical professionals as related to my treatment.

Patient/ Guardian Signature: _____ Date: _____

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MEDICAL HISTORY FORM

Patient's Name: _____ Today's Date: _____

Occupation: _____ Date of Injury: _____

Have you experienced these symptoms before? □Yes□ No (if yes, when?)

Have you had surgery related to this condition? □Yes□ No

If yes, what type of surgery? _____ Date of Surgery: _____

PLEASE CHECK IF YOU HAVE, OR HAD ANY OF THE FOLLOWING BELOW:

□Diabetes
□Chest pain/ Angina
□Heart Disease
□High Blood Pressure
□Heart Attack
□Pacemaker
□Vascular Disease
□CVA/Stroke/TIA
□Seizures
□Skin Abnormalities
□Sexual Dysfunction
□Nausea/ Vomiting
□COPD
□Thyroid Disease
□Osteoporosis/ Osteopenia
□Arthritis
□Hernia
□Recent fractures
□Headaches/ Migraines
□Dizziness/Fainting
□Kidney Disease
□Bowel/Bladder disease
□Liver/ Gallbladder Disease
□Metal Implants
□Ringing/ fullness in the ear
□HIV
□Hepatitis
□Asthma
□Depression
□Anxiety
□Allergies
□Cancer: (what type)
_____
_____
Are you pregnant? □Yes□ No
Do you smoke? □Yes □No

Please list all surgeries you have had and dates: _____

_____

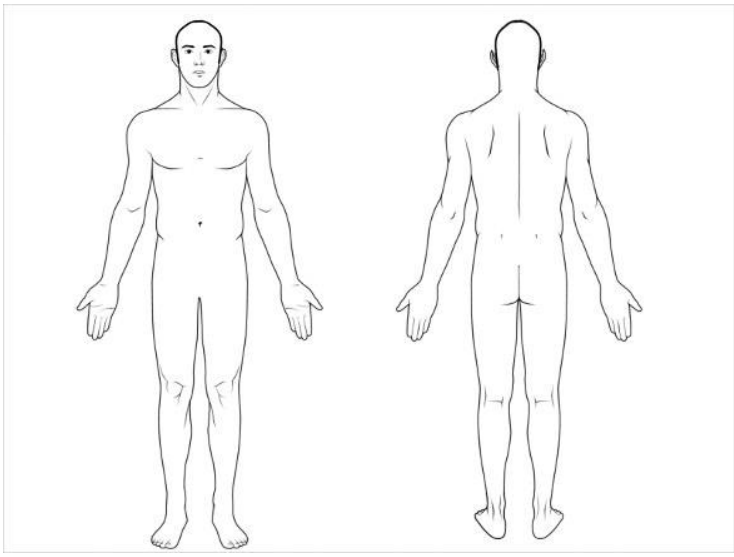
Please list all medications (attach list if needed): _____

_____

Patient/ Guardian Signature: _____ Date: _____

Body Chart:

Mark the areas where you feel your symptoms.



On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10

Cannot do anything Able to do

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Current History:

What date (approximately) did your present symptoms start? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed? getting better about the same getting worse

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) _____

What treatments have you received for this problem so far? _____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

1) _____
2) _____
3) _____

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT,

osteopath, etc.)? Yes / No If yes, please describe the reason. _____

_____

List any other injuries you have had that required medical attention. _____

_____

What are your personal goals for therapy at this time? _____

_____

List any physical activities that you participate in (ex: running, swimming, tennis, etc.)

_____

_____

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Financial/Rescheduling Policy

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of physical therapy and insurance plans**. Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.**

Here at Missing Link, we feel that we can best care for our patients if we are able to spend up to a full hour with our new patients on their first appointment. Because of the high demand for these appointments it is critical that you arrive in the office 10 minutes prior to your appointment with your completed forms. We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

We understand situations arise in which you must cancel your appointment. It is therefore requested if you must cancel or reschedule your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations/reschedules made less than 24 hours' notice, we are unable to offer that appointment to other patients.

There will be a $150.00 fee charged to all patient's/ clients who miss scheduled appointments and fail to cancel their scheduled appointment without 24-hour notice. We understand that illness and emergencies happen and we will take that into full consideration if the situation arises and will waive the fee as necessary. Patients who No Show two (2) or more times in a twelve (12) month period, may be dismissed from the practice thus being denied any future appointments.

Missing Link Physical Therapy is an out of network Physical Therapy practice. Payment is to be provided on the date of service unless payment arrangements have been made and approved in advance. We will provide the appropriate invoice so that you may submit the service provided to your insurance company for possible reimbursement. For your convenience, we accept all major credit cards and payments can be made over the phone. **PLEASE NOTE THAT YOU WILL BE CHARGED $35.00 FOR ANY CHECKS WITH NONSUFFICIENT FUNDS.**

Signature: _____ Date: _____

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Disclosure Authorization-For Release of Protected Health Information

I have read and fully understand Missing Link Physical Therapy's Privacy Practices. A copy of the Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Missing Link Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Missing Link Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Missing Link Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: _____ Date: _____

Communication of Health Information

I give permission to Missing Link Physical Therapy to disclose and discuss any information related to my medical condition (s) with the following individuals:

Name: _____Relationship/Contact Info: _____

Name: _____Relationship/Contact Info: _____

Name: _____Relationship/Contact Info: _____

☐ I do not wish to disclose any information related to my medical condition(s).

Signature: _____ Date: _____