physical therapy specialists

INTAKE QUESTIONNAIRE

Patient Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone – Please Select Primary #: ☐ Mobile ☐ Home ☐ Work

(Mobile) _____ (Home) _____

(Work) _____ Email: _____

Emergency Contact: Appointment reminder sent to email? ☐ **Y** / ☐ **N**

Name: _____ Relationship: _____

Emergency contact #: _____ (☐ Mobile ☐ Home ☐ Work)

Insured/Responsible Party Information: Name: _____ **DOB:** _____

I have a "Digital" Insurance Card: Carrier: _____ **ID#:** _____

Is there an individual you would like us to be able to communicate with regarding your treatment plan (ie. spouse, parent, child)?

☐ Yes, same as emergency contact
☐ Yes, someone other than emergency contact
☐ No

Name: _____
Relation: _____
Phone: _____

Medical History:

Referring Physician (if any) : _____ Primary Physician/PCP: _____

Diagnosis/Reason for this visit: _____ Date of Injury/Onset: _____

Have there been previous episodes of this condition ( ) About how many? (____) Year of 1st episode (_____)

Have you been treated for this condition before ( ) Where? _____

Have you recently received Home Care Services? ( ) End Date? _____

*** If you are currently receiving Homecare, outpatient services cannot begin until you are discharged from <u>all</u> Homecare Services**.

During the past month, have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

- **Do you have, or had you had, any of the following:** <u>Check all that apply</u>

☐ Allergies: _____
☐ Fever/Night Sweats/Weight Loss/Gain
☐ Osteoporosis / Osteopenia
☐ For Women: Are you pregnant? **(____)**
☐ Heart Attack, High Blood Pressure, or
☐ Other Cardiac Problems

☐ Arthritis
☐ Balance Problems
☐ Depression, Anxiety
☐ Pacemaker Inserted
☐ HEP B, HEP C, Hypothyroid, Other
☐ Endocrine Issues
☐ Thrombosis, DVT, PVD, PAD

☐ Cancer (Type):
☐ Diabetes
☐ Artificial Implants
☐ Do you smoke?
☐ Stroke, Seizures, Headaches,
☐ Numbness/Other Neurologic Issues
☐ Anemia, Raynaud's, Other Circulatory/Blood problems

Current Medications:

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>

*** If you do not have all medication information with you today, please bring an updated list on your next visit.***

Physical Therapy Specialists of Guilford
705 Boston Post Road A-5
Guilford, CT 06437
Phone: 203-458-1645 Fax: 203-458-1689

Physical Therapy Specialists of Old Saybrook
840 Boston Post Road Unit 200
Old Saybrook CT 06475
Phone: 860-391-8175 Fax: 860-391-8197

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INTAKE QUESTIONNAIRE

Consent for Care & Treatment

Authorization for Treatment

I hereby give consent for the performance of rehabilitation procedures, as permitted by Connecticut Statutes, by Physical Therapy Specialists of Guilford, under the appropriate scope of practice that are, in the judgment of my Therapist, deemed necessary.

Release of Information / Financial Responsibility

Authorization for Release of Information

- I agree that Physical Therapy Specialists of Guilford may provide information from my medical record to persons involved in my medical care.
- I authorize the release of medical information necessary to obtain payment of any benefits available to me to Physical Therapy Specialists of Guilford for services rendered.
- I agree that Physical Therapy Specialists of Guilford may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.
- I have read, or been offered to read, "Notice of Privacy Practices" mandated by HIPAA.

Authorization for Release of Payment

- I authorize that direct payment of any benefits available to me be released to Physical Therapy Specialists of Guilford for services rendered.

Patient Agreement

- I agree to pay Physical Therapy Specialists of Guilford charges for services rendered to me during my course of treatment.
- I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Physical Therapy Specialists of Guilford collections costs including attorney and court fees.
- I certify that all information provided herein is true and correct to the best of my knowledge.

Medicare, Medicaid, and Similar Benefits (if applicable)

- I agree that the information given to Physical Therapy Specialists of Guilford in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Physical Therapy Specialists of Guilford may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
- **WE DO NOT ACCEPT MEDICAID/HUSKY CONNECT CARD IF YOU ARE 21 OR OLDER. INDEPENDENT PHYSICAL THERAPY IS NOT COVERED. MEMBER MUST RECEIVE SERVICES IN A HOSPITAL OUTPATIENT CLINIC SETTING.**
- **We do accept QMB Plans (Qualified Medicare Beneficiary Plans)**

Workers Compensation (if applicable)

I agree that the information given to Physical Therapy Specialists of Guilford in applying for benefits under Workers Compensation is complete and accurate. I agree that Physical Therapy Specialists of Guilford may give intermediary's information necessary to process claims.

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this consent form.

Printed Name	**Patient or Guardian Signature**	**Date**

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