Patient Intake Form

PATIENT INFORMATION

Last Name:_____First Name: _____Middle:_____

DOB: _____ Age: _____ Sex ◯ Male ◯ Female

Address: _____

Contact #: Cell _____/Home_____/Work_____

SSN: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ DOB _____

If you are a guardian, please specify your relationship to the above patient: _____

Address: _____

Contact #: Cell _____/Home_____/Work_____

SSN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Subscriber's Name:_____DOB: _____

Member's ID Number: _____Group #_____

Subscribers SS# _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Other

SECONDARY INSURANCE CARRIER

Subscriber's Name:_____ DOB:_____

Member's ID Number:_____Group#_____

Subscribers SS# _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Other

CONSENT TO THERAPY

1. **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at ***Melanie Massey 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 hereunder, do hereby agree and understand that I have been advised of ***Melanie Massey Physical Therapy's*** waiting room policies and treatment.
3. **LIABILITY**: I know and agree that ***Melanie Massey Physical Therapy*** is not responsible for loss or damage to personal valuables.
4. **WAIVER AND RELEASE**: I hereby release, discharge and acquit ***Melanie Massey Physical Therapy***, its agents, representatives, affiliates, employees, or assigns, of and from any and 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 hereby assign all benefits directly to ***Melanie Massey Physical Therapy*** and also authorize release of any medical records necessary to facilitate my treatment process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

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

Patient/Guardian Signature:_____Witness Signature:_____

Patient/Guardian Print:_____Witness Print:_____

DISCLOSURE AUTHORIZATION – FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I have read and fully understand **Melanie Massey Physical Therapy** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that **Melanie Massey 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 hereby consent to the use and disclosure of my personal health information for purposes as noted in **Melanie Massey 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.

Patient Name:_____ Date _____

COMMUNICATION OF HEALTH INFORMATION

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

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____INITIALS

CONTACT INFORMATION

I wish to be contacted in the following manner(s):

Home Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with family members or other persons living in the same household

Work Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with secretary, assistant, or other individual who regularly answers the phone

Cellular Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

Patient/Guardian Signature:_____ Date: _____

FINANCIAL POLICY

Thank you for choosing ***Melanie Massey Physical Therapy*** as your therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your treatment.

Payment of services is due prior, or upon completion of each treatment visit. We accept ***CASH, MASTERCARD, VISA, DISCOVER***, ***or PERSONAL CHECKS***. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of may result in a shortened treatment or cancellation.

_____INITIALS

PRIVATE INSURANCE

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy, we extend to our patients, all charges are your responsibility from the date of services rendered.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment.

Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim.

_____INITIALS

PRIVATE PAY AND AFTERCARE

If you do not have insurance or just wish to self-pay, we do have a rate for our Self-pay, Aftercare and Massage patients. You may inform the front desk staff if you are interested. Self-pay, Aftercare and Massage patients will be collected at time of appointment.

_____ INITIIALS

MEDICARE PATIENT

Melanie Massey Physical Therapy are providers for Medicare, and we will take the responsibility of submitting your claims for you. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it has not been met at the time of service, and the co-insurance if there is no secondary. ***If you are receiving Home Health, you must inform our front desk staff immediately before or anytime during treatment. Home Health may mean getting your blood pressure check, injections etc.*** Medicare does have a yearly money cap which our staff will keep you informed when you are approaching the money limit. Medicare will not pay for certain supplies or any over the limit dollar amount. Before proceeding with treatment or giving any supplies that Medicare will possibly not pay, our front desk staff will then explain an ABN form and have you to sign with your decision. A signed ABN will be placed in your medical record file.

_____INITIALS

PEDIATRIC POLICY

SICK/CANCELATION POLICY

In order to provide a safe and "well" environment for all the patients and staff, we require your child to be free from fever and vomiting for 24 hours.

No-show is someone who misses their appointments without cancelling. Our front desk staff will attempt to call and reschedule, but if they are unsuccessful attempts to make-up or reschedule, we will remove your child from our reoccurring appointment schedule. We will be happy to assist you with any available appointment.

_____ INITIALS

PHOTO PERMISSION

1. I give permission to photograph/videotape of my child for the purposes of treatment, education, and documentation. ***Initial and date*** _____/_____
2. I give permission to photograph/videotape of my child to be used for advertising, brochure and/or social media. ***Initial and date*** _____/_____

WAITING ROOM

In order to best address everyone's needs, parents and family members are asked to remain in waiting room area unless otherwise requested by your therapist. If you would like to leave during your child's treatment, please provide adequate contact numbers to the front desk staff in order to reach you if any problems should occur during therapy. Please let our front desk staff know if you need to schedule a meeting to talk about your child's plan of care.

_____ INITIALS

I have read, understand, and agree to ***Melanie Massey Physical Therapy Pediatric Policy***. I am also aware of, and understand my policy benefits for treatment.

Patient/Guardian Signature:_____Date: _____

Patient/Guardian Print:_____

Witness Signature:_____ Date: _____