Cornerstone Wellness Center

Physical Therapy Intake Form

Patient Information:

Last Name: _____ First Name: _____ Sex: _____

Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Cell #: ( ) _____ - _____ Home #: ( ) _____ - _____

Email: _____ Work #: ( ) _____ - _____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Partnership____

Employer's Name: _____ Occupation: _____

Physician's Name: _____ Phone #: ( ) _____ - _____

Is your injury work related or auto related?: _____ Allergies: _____

Emergency Contact: _____ Phone #: ( ) _____ - _____

Insurance Information:

Insurance Co Name: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ SS#: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer's Name: _____

Patient Signature: _____ Date: _____

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Patient History

Name: _____ Date of Birth: _____ Right or Left Handed: ____

What is your main complaint?:_____

_____

Rate your main complaint in order of severity from worst (10) to least (1): _____

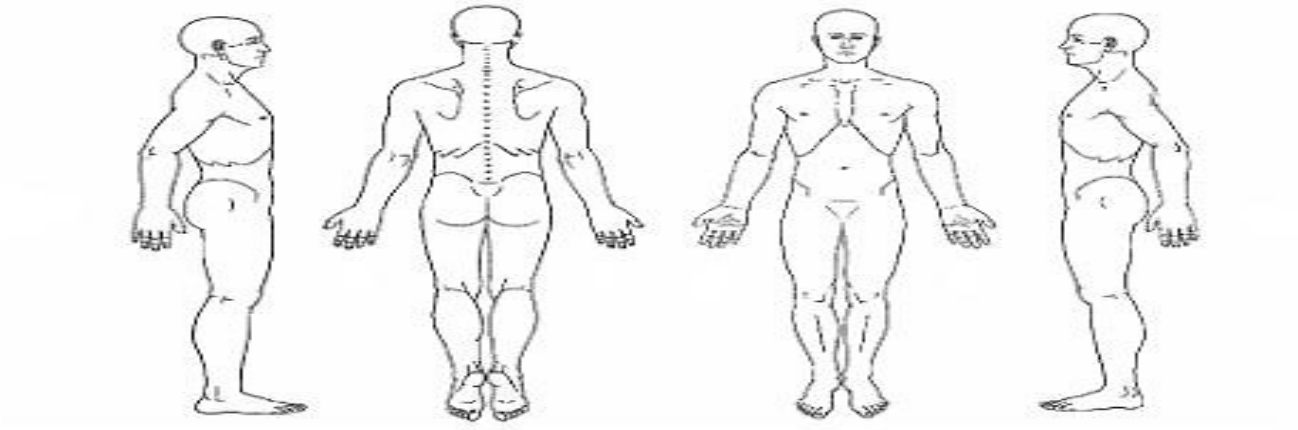
At it's worst: ____ At it's best: ____ Worse in the: ____ AM ____PM ____ Constant ____ Inconsistent

Are your symptoms: _____ Improving _____ Worse _____ Stable

Where is your main concern? Indicate on the body chart. Pain= x

Indicate the nature of your pain and symptoms?: ___ Sharp ___ Dull ___ Piercing ___ Shooting

___ Aching ___ Deep ___ Shooting ___ Tingling ___ Numbness ___ Intermittent ___Burning



When and how did this problem begin?: _____

What makes your symptoms/ pain worse?: _____

What makes your symptoms/ pain better?: _____

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Social History

Are you presently working? _____ Yes, _____ No, since _____

_____

Physical/Emotional demands of present occupation? (High, Moderate, minimal) _____

_____

Overall activity level: _____Sedentary _____ Light _____Moderate _____ Heavy _____Very Heavy

Sports and Exercise (Type, Frequency, Duration) _____

_____

Use of Tobacco: _____ Yes _____ No Use of Alcohol: _____Yes _____ No # per week? _____

Family Medical History:

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?

_____

_____

Please list 3 goals of Physical Therapy and time frames:

1) _____
2) _____
3) _____

Who can we thank for this referral?

_____

Thank you for your patience and valuable time!!!

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Medical History

Do you exercise beyond daily activities: Days per week:_____ What type of exercise:_____

Any major life changes in the past year: _____ Yes _____ No If yes, explain:

_____

Do you have any allergies: _____Yes _____ No If yes, list: _____

Please check if you have ever had:

□Arthritis
□Osteoporosis
□Heart problem
□Lung problem
□Diabetes
□Head injury
□Muscular dystrophy
□Seizures/epilepsy
□Thyroid problem
□Cancer
□Hepatitis
□Repeated infections
□Skin diseases
□Pacemaker
□Hernia
□Concussion
□AIDS/HIV
□Appendicitis
□Broken bones
□Blood disorders
□High blood pressure
□Stroke
□Hypoglycemia (low blood sugar)
□Multiple Sclerosis
□Parkinson's disease
□Allergies
□Developmental (growth) problem
□Tuberculosis
□Kidney problems
□Ulcers/stomach problems
□Depression
□Fibromyalgia
□Migraines
□Asthma
□Anemia
□Circulation/vascular problems
□Other_____

Within the past year have you had any of the following?

□Chest pain
□Heart palpitations
□Cough
□Hoarseness
□Shortness of breath
□Dizziness or blackouts
□Coordination problems
□Headaches
□Fever/chills/sweats
□Difficulty walking
□Joint pain or swelling
□Pain at night
Men: Prostate disease □No □Yes
Women: □Pelvic inflammatory disease
□Trouble with your periods □Complicated pregnancy
□Currently pregnant
□Other_____
□Difficulty sleeping
□Loss of appetite
□Nausea/vomiting
□Difficulty swallowing
□Bowel problems
□Weight loss/gain
□Urinary problems
□Weakness in arms or legs
□Loss of balance
□Hearing problems
□Vision problems
□ Other
□Endometriosis

Current Medications:	Surgeries (include year)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Physical Therapy Consent From

Consent: I consent to and authorize Jennifer Leach PT, DPT and Jarrett Holmes, PTA to provide physical therapy services to me. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the therapist about any health problems or allergies I have, as well as medications I am taking. It is also my responsibility to inform the therapist if I am uncomfortable during any given technique or treatment.

Minor Patients: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) cannot be given treatment, unless the parent or guardian has signed patient and financial responsibility forms.

Release of Information: I understand that no records will be transferred or information about my case can be shared with any other medical provider or entity without my specific request and authorization.

No Guarantees: I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

Payment: Cash, check, and credit card payments are accepted. We also accept Care Credit and HSA/FSA cards. Payment plans may be available. We are an out-of-network provider for all insurances. Insurance will be verified to determine if there are available benefits.

No Show/Cancellations/Late Fee Policy: Cancellations with less than 24 hour notice will result in a $25 fee.

Patient Name: _____

Patient Signature: _____

Date: _____

Office Policy, Procedures & Disclosures

Cancellation Policy:

There is a $35 charge for missed appointments without a 24-hour advance notice for any appointment with the Chiropractor, Physical Therapist, Acupuncturist and/or the Massage Therapist. For those patients who have purchased a massage package, one massage will be used from the package if the appointment is not cancelled 24 hours before the scheduled massage.

Consent to care

As a patient with Cornerstone Wellness Center, you have the right to know the types of treatment we could possibly use and any complications/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however, unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. Patients are responsible for informing doctors about any conditions, diseases, illnesses, etc. Patients agree to settle any claim or dispute against or with our clinic or personnel, when related to the prescribed care or otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. Cornerstone Wellness Center may refer you out to other ancillary services that Cornerstone Wellness Center may have ownership to. Patients hereby allow treatment to be rendered to themselves by all Cornerstone Wellness Center, physicians or staff.

Financial Policy

The patient is ultimately responsible for full payment of their treatment and care whether or not paid by insurance. Your insurance Policy is a contract between you and your insurance. As a courtesy, we check your insurance for benefits. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payments of co-pays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients authorize the release of healthcare information and records to all insurance companies. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit and debit cards at our office. Any prepaid packages are refundable if not used within 90 days of payment. After 90 days, the unused portion will revert to a credit which must be used within 2 years of original payment. Any credits not used within the two years will be forfeited. Any insurance checks sent directly to you or the insurance policy holder for services rendered with Cornerstone Wellness Center must be brought into our clinic.

Collections

If a patient's account is not paid in full within 90 days, it will be considered delinquent. No additional appointments will be made for patients with delinquent accounts until they are current. Delinquent accounts will be turned over to a licensed collection agency; there will be a collection fee equal to 30% of our outstanding balance at the time the account is placed with the collection agency.

Miscellaneous:

There is a $35 charge for forms completion by our Providers, including but not limited to disability and FMLA forms.

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I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Printed Patient Name: _____ Date: _____

Signature of Patient: _____Witness:_____

Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving **Cornerstone Wellness Center authorization** to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- I may be contacted by home, work, or cellphone.
- Messages may be left on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- Also I may be contacted by postal mail or e-mail to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders.
- With my permission, my name and or photograph may be used for office events, bulletin boards, newsletters or patient testimonials.

You have the right to revoke this AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the privacy Official of **Cornerstone Wellness Center.** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Officials.

This AUTHORIZATION is requested by **Cornerstone Wellness Center** for its own use/ disclosure of protected health information. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION **Cornerstone Wellness Center** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU **

Personal representatives (family members, attorneys, etc. I hereby authorize **Cornerstone Wellness Center** and its employee's to discuss, send and/ or receive medical information to/with the following individuals:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? Yes No

If yes, please provide us the following information: Primary Care Doctor_____Office Phone#_____

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of **Cornerstone Wellness Center** Notice of Privacy Practices.

Patient Name (print):_____ Patient Representative (print):_____

Patient Signature:_____ Patient Representative Signature:_____

Date:_____/_____/_____