

# MONTESANO PHYSICAL THERAPY, INC. Patient Intake Information

PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date:	/	/
Address:	City:	State:	Zip:		
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #:	-	-
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:			
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend					
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					
WORK INFORMATION					
Employer:	Work Phone ( ) -	Ext.			
Occupation:	Employment Status	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Not Employed
CARE PROVIDER INFORMATION					
Referring Dr:	Referring Dr. Phone: ( ) -				
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -				
INSURANCE INFORMATION ( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )					
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date :	/ /
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date :	/ /
ID. #:	Group/Policy #				
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM ( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )					
Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:					
Adjuster/Claim Manager:			Phone:	Ext.:	
Address:		City:	State:	Zip:	
Claim #:	Accident Date: / /	Cause:			
ATTORNEY INFORMATION					
Name:		Law Firm:	Phone: ( ) -		
Address		City:	State:	Zip:	
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -			

I authorize my insurance benefits be paid directly to MONTESANO PHYSICAL THERAPY, Inc.. I understand that I am financially responsible for any balance. I also authorize \_\_\_\_\_ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

# PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Other: _____		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative \_\_\_\_\_

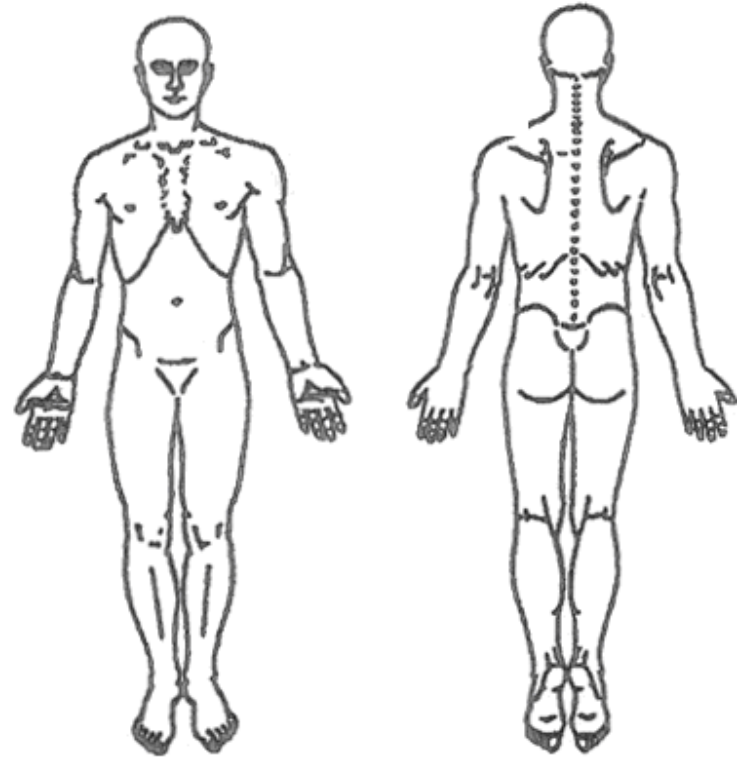
Date \_\_\_\_\_

# Pain and Symptom Status Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- |   |                              |                                |
|---|------------------------------|--------------------------------|
| <b>Ache</b><br>MMM<br>M                         | <b>Burning</b><br>---<br>--- | <b>Numbness</b><br>OOOO<br>OOO |
| <b>Pins and Needles</b><br>□□□□□□□□<br>□□□□□□□□ | <b>Stabbing</b><br>/////     | <b>Other</b><br>xxxx<br>xxx    |

## Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

<b>Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
<b>Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
<b>Please circle on the scale below to indicate your <u>WORST</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it

Additional Comments \_\_\_\_\_

## NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **MONTESANO PHYSICAL THERAPY, INC.'S LEGAL DUTY**

MONTESANO PHYSICAL THERAPY, INC. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

MONTESANO PHYSICAL THERAPY, INC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

MONTESANO PHYSICAL THERAPY, INC. may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

MONTESANO PHYSICAL THERAPY, INC. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. MONTESANO PHYSICAL THERAPY, INC. will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

MONTESANO PHYSICAL THERAPY, INC.

Attn: Privacy Officer

508 E. PIONEER AVE.

MONTESANO, WA 98563

PHONE: (360) 249-4185

## PATIENT INFORMATION CONSENT FORM

I have read and fully understand MONTESANO PHYSICAL THERAPY, INC.'s Notice of Information Practices. I understand that MONTESANO PHYSICAL THERAPY, INC. 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 MONTESANO PHYSICAL THERAPY, INC. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in MONTESANO PHYSICAL THERAPY INC.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

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Patient Name

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Signature

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Date

I authorize MONTESANO PHYSICAL THERAPY, INC. to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

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Patient Name

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Signature

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Date

# MONTESANO PHYSICAL THERAPY, INC. POLICIES

## TIMELINESS

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected event with another patient but be assured that the quality of your time will not suffer. If you arrive late, your treatment will end at its scheduled time in order not to keep the next person waiting.

## NO SHOWS

If a patient fails to show for 2 scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and their physician and case coordinator will be notified.

## BILLING INFORMATION

Cascade Billing Center will be handling the insurance and patient billing for MONTESANO PHYSICAL THERAPY, Inc. They are located in Tumwater with a mailing address of 1870 Barnes Blvd. SW Olympia, WA 98512-1880.

You will receive a statement from them with a convenient envelope only after your insurance company has been billed and has responded. If your insurances pay your account in full, there will be no statement sent to you. Most insurance companies will notify you as to how they chose to pay your account. A 1% surcharge will be place upon all accounts over 60 days late.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. **Therefore, it is the patient's responsibility to determine what their insurance company will allow for physical therapy, obtain prior approval if necessary, and follow up with their insurance company on all unpaid visits.**

In the event it becomes necessary for MONTESANO PHYSICAL THERAPY, Inc. to incur any costs of collection on the patient's account including but not limited to any legal action, cost of litigation expenses and MONTESANO PHYSICAL THERAPY, Inc., is deemed the prevailing party the patient shall be responsible for all such costs and reasonable attorneys fees in connection therewith. It is agreed that the venue of any legal action brought under the terms of this agreement shall be in Grays Harbor County, Washington.

Sending you a statement only after the insurance has paid is to help conserve paper products and reduce the high costs of postage.

Co-payments are due at the time of each treatment.

Cascade Billing Center will be happy to answer any questions and can be reached in Olympia at 360-352-2037 or 1-800-682-2037 between 8:30 and 5:00 M-F.

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## PATIENT CONSENT AND RELEASE

I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor and Industries claims. I understand the parent accompanying any minor for treatment will be responsible for payment. I authorize MONTESANO PHYSICAL THERAPY, Inc./Cascade Billing Center and its subsidiaries to release any necessary information requested by my insurance carrier and authorize payment directly to MONTESANO PHYSICAL THERAPY, Inc./Cascade Medical Billing and its subsidiaries for any benefits available under my insurance plan. I hereby consent to treatment by Joe Arndt JR. P.T. and Duncan Durr M.P.T.

I acknowledge that I have read and understand the billing and no show information above.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian's Signature

\_\_\_\_\_  
Date