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:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ 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 Montesano Physical Therapy, Inc. to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ 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 a 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

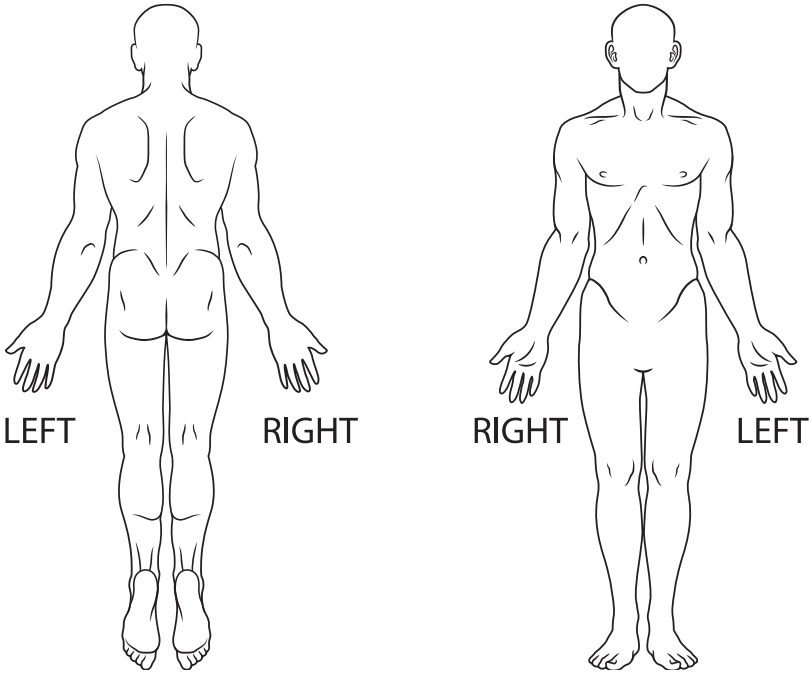
Pain and Symptom Status Report

Name _____ Date _____

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

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0

Pins and Needles	Stabbing	Other
□ □ □ □ □ □	/////	x x x x
□ □ □ □	////	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

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

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____

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 heath/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.

_____
Patient Name

_____
Signature

_____
Date

MONTESANO PHYSICAL THERAPY, INC. POLICIES

TIMELINES

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 to not 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 1FORMATION

Olympic Medical Billing, LLC. will be handling the insurance and patient billing for MONTESANO PHYSICAL THERAPY, Inc. They are located in McCleary with a mailing address of P.O. Box 559, McCleary, WA 98557.

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 there with. 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.

Olympic Medical Billing will be happy to answer any questions and can be reached in McCleary at 360- 470-1799 between 8:30 and 5:00 M-F.

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., Olympic Medical Billing, LLC. and its subsidiaries to release any necessary information requested by my insurance carrier and authorize payment directly to MONTESANO PHYSICAL THERAPY, Inc., Olympic Medical Billing, LLC. 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