HEALTH INTAKE FORM

Please fill out form entirely and bring it with you to your first office visit.

Name_____ Date of Birth _____

A. Reason for Visit

Reasons for your visit, current problematic body areas, and your personal goals _____

_____

_____

Date of onset of problem being treated _____

What helps? _____

What other current or past treatments have you tried? _____

_____

What makes it worse and what activities do you avoid? _____

_____

B. Health Information

Have you had any Physical Therapy in the last year? _____

Are you currently receiving health care? Where and from whom? _____

_____

Current Medical Issues _____

_____

Relevant Family History _____

For therapy related to cancer diagnosis

Type of cancer and location _____Date of Diagnosis _____

Surgery? _____ Procedures and dates_____

Lymph node removal? _____ Location and number if known _____

Radiation? _____ Body location and schedule _____

Chemotherapy? _____ Type and Schedule _____

Past Medical Issues including surgery, injury, medical history _____

_____

HEALTH INTAKE FORM continued

Name_____

Occupation_____

Physical demands of your job _____

Current Activity Level: Types of exercise _____

How many minutes? _____ How many times a week? _____ At what intensity? _____

Hobbies_____

Every client please complete / <u>Required for Medicare Reimbursement</u>

Current Medications: prescription, over the counter, and nutritional supplements (herbs, vitamins, minerals). Include name of medication, dosage, frequency, and route (example: oral, sublingual, injections, topical). _____

_____

_____

_____

Body Mass Index (BMI required for Medicare patients): Height _____ Weight _____

Falls Risk Assessment: Have you had any falls in the past year? _____

Did any falls result in an injury? (please describe) _____

C. Symptom Assessment

1. Pain Assessment: Please circle to rate your <u>current</u> state. (0=no pain, 10=worst possible pain)

0 1 2 3 4 5 6 7 8 9 10

2. Daily Activities: Please circle to rate your <u>current</u> state (0=no limitations, 10=extremely limited)

0 1 2 3 4 5 6 7 8 9 10

D. Family and Friend Support

Who is involved in your care? _____

What other health concerns or comments do you have which are not covered in this form?

_____

E. Consent of Care

It is my choice to receive physical therapy or massage therapy at New Leaf, and I give my consent to receive such treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature X_____ Date_____

BILLING INFORMATION AND POLICIES

Please complete this form and bring it with you to your first office visit.

A. Patient/Client Information

Preferred Name _____

Full Name_____ Date of Birth _____ Gender _____

Address_____ City_____ State_____ Zip_____

Email _____ Home Phone_____

Work_____ Cell_____ Social Security Number _____

How would you prefer appointment reminders? ☐Email or ☐ Text: Cell Phone Company_____

Emergency Contact's Name _____ Relationship _____ Phone _____

How did you hear about New Leaf services? _____

B. Primary Insurance Coverage (if not using insurance and paying in full at visit, check here ☐)

Insurance Company _____ ID#_____

Group # _____Plan # or Name _____

Phone # on back of card_____ Relationship of Patient/Client to Insured _____

Insured's Full Name_____ Date of Birth _____ Gender _____

Address_____ City_____ State_____ Zip_____

Phone Home_____Work_____Cell_____

C. Secondary Insurance Coverage

Insurance Company _____ ID#_____

Group # _____Plan # or Name _____

Phone # on back of card_____ Relationship of Patient/Client to Insured _____

Insured's Full Name_____ Date of Birth _____ Gender _____

Address_____ City_____ State_____ Zip_____

Phone Home_____Work_____Cell_____

BILLING AND POLICIES continued

Name_____

D. For Workers' Compensation Cases: Employer's Name _____

Address_____ City_____ State_____ Zip_____

Phone _____ Fax _____ Claim # _____

E. Referring Provider: Name _____ Company _____

Address_____ City_____ State_____ Zip_____

Phone _____ Fax _____

F. Primary Care Provider: Name _____ Company _____

Address_____ City_____ State_____ Zip_____

Phone _____ Fax _____

G. Other Health Care Providers or Professionals

Name _____ Phone _____

Name _____ Phone _____

H. Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims.

I. Assignment of Benefits and Financial Responsibility

My signature below authorizes direct payment of medical benefits for services billed to New Leaf Physical and Massage Therapy LLC. I authorize the use of this signature on all insurance submissions. It is my responsibility to pay for all services provided. I understand that I am responsible for all co-payments at the time of each service. I am responsible for the balance of any uncovered services not paid by the insurance companies.

J. HIPAA Compliance Acknowledgement (Health Insurance Portability and Accountability Act)

I understand that my medical record will be kept private. I understand that the clinical and support staff at New Leaf Physical and Massage Therapy, LLC will have access to my medical record. I acknowledge that my information will never be disclosed to anyone without my consent, except in the case where it is mandated by state law. I understand that I may request a copy of my medical chart by paying the set fee for photocopying services.

Patient/Client Signature X_____ Date _____

BILLING AND POLICIES continued

Name_____

K. New Leaf Cancellation and Late Arrival Policy

We are committed to providing you with excellent service. Your appointment time is *valuable* and reserved specifically for you and your therapist. If you must cancel, please allow us a minimum of 24 hours' notice prior to your scheduled visit in order to offer your time to other clients on our wait list. Leaving a voicemail is an acceptable form of notification; however, messages will only be heard during business hours Monday through Friday. If your appointment falls on a Monday or after a holiday, you must call to cancel by the business day prior.

- You will be charged a **$50 cancellation fee** if you cancel your appointment with less than 24 hours' notice or if you do not show up for your scheduled appointment.

- You will be charged **$35** if you are more than 15 minutes late for your scheduled appointment.

- After three no shows or cancellations without 24 hours' notice, you will be charged **$100** and your therapist will discuss modifications to your plan of care.

Patient/Client Signature X_____ Date _____