New Patient Intake Form

Patient Information

Name: _____ Social Security #_____

Date of Birth: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Emergency Contact

Name: _____ Phone Number: _____

Employer

Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Insurance

Primary Ins: _____ ID# _____

Group #_____ Subscriber: _____ DOB: _____

If medicare: Have you been on Home Health Services? _____ Discharge Date: _____

Secondary Ins_____ID#_____

Group #_____ Subscriber: _____ DOB: _____

If medicare: Have you been on Home Health Services? _____ Discharge Date: _____

Workers Comp: Paying Agency/State: _____ Case #_____

Case Manager: _____ Phone #: _____ Date of Injury: _____

Employer at the time of injury: _____ Supervisor: _____

Supervisors Phone #: _____

Problem/Patient Information Form

Problem Description: _____

Date of injury: _____ Last Physician Visit: _____

Referred by: _____ Notes/Comments: _____

Have you had surgery for this injury: _____ If so when: _____

Type of Surgery: _____

Have you had any of the following services for this injury?

Chiropractor	Y	N	CT Scan	Y	N
Massage Therapy	Y	N	MRI	Y	N
Mylogram	Y	N	Neurologist	Y	N
Physical Therapy	Y	N	Orthopedist	Y	N
Occupational Therapy	Y	N	Podiatrist	Y	N
Emergency Room Care	Y	N	X-Rays	Y	N
EMG	Y	N	Other: _____	Y	N

Current Level of pain: (0=No pain, 10=Worst pain): 1 2 3 4 5 6 7 8 9 10

Are you currently taking any prescription medications: Y N if yes, please list:

_____

Do you have or have you ever had any of the following?

Asthma, Emphysema	Y	N	Severe or Frequent Headaches	Y	N
Shortness of breath/Chest pains	Y	N	Vision or Hearing Difficulties	Y	N
Coronary Heart Disease	Y	N	Numbness or Tingling	Y	N
Pacemaker	Y	N	Dizziness or Fainting	Y	N
Heart Attack/Surgery	Y	N	Bowel or Bladder problems	Y	N
Stroke/TIA	Y	N	Weakness	Y	N
Congestive Heart Disease	Y	N	Weight loss/Energy Loss	Y	N
Blood Clot	Y	N	Hernia	Y	N
Epilepsy/Seizures	Y	N	Varicose Veins	Y	N
Thyroid Disease	Y	N	Allergies	Y	N
Anemia	Y	N	Any pins or metal implants	Y	N
Infectious Disease	Y	N	Joint Replacement Surgery	Y	N
Diabetes	Y	N	Neck Injury/Surgery	Y	N
Cancer/Chemotherapy/Radiation	Y	N	Elbow/Hand injury/Surgery	Y	N
Arthritis	Y	N	Back Injury/Surgery	Y	N
Osteoporosis	Y	N	Knee Injury/Surgery	Y	N
Gout	Y	N	Leg/Ankle/Foot injury/Surgery	Y	N
Sleeping Problems/Difficulties	Y	N	Are you pregnant?	Y	N
Emotional/Psychological problems	Y	N	Do you Smoke?	Y	N

List any other information that would assist us in your care: _____

What are your Rehabilitation expectations/goals while in therapy: _____

HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers, who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been given the right to review such Notice of Privacy practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice.

I understand that I may request in writing that MyoFit Clinic restrict how my private information is used or disclosed to carry out treatment, payment, or health care options. I also understand MyoFit Clinic is not required to agree to my requested restriction, but if they do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that MyoFit Clinic has taken action relying on this consent.

Patients Name (Please Print) : _____

Signature of Patient or Representative: _____

Relationship to Patient: _____ Date: _____

MyoFit Clinic Billing Overview

Your understanding of our financial policies is an essential element of your care and treatment here at MyoFit Clinic. If you have any questions, please discuss them with our front office staff or receptionist.

MyoFit Clinic strives to be completely transparent when it comes to billing your insurance and you as the patient. We want to make sure you fully understand how the billing process works to eliminate any question you may have if/when you receive a monthly statement. We know the burden of healthcare costs falls mostly on you the consumer these days and MyoFit Clinic wants to help decrease large monthly statements for you.

Prior to your first appointment we verify your insurance and put together what we call an **Insurance Acknowledgement Form**. This form is reviewed with you when you come in for your first appointment by the receptionist and requires your signature. This will lay out the financial responsibility for therapy services stated by your insurance company. This is not a guarantee of payment by your insurance company. This is known as a verification of your benefit. To lower the amount of liability for your physical therapy services on your final statement an amount prepaid is required each date of service. This amount paid at each date of service may not cover the entire date of service. The total amount owed is determined by your insurance company, it is sent to MyoFit Clinic on an Explanation of Benefits just like the one you receive. Below is an **Example of a hypothetical account in simple numbers** to help you better understand the process.

Example:
You come in for 4 separate dates of service. Each time you come in you pay $30.00. You now have $120.00 sitting on your MyoFit Clinic account. That amount sits on your account until we receive the Explanation of Benefits (EOB) from your insurance company.

We bill your insurance company and receive the first 2 dates of service back on an EOB.

Explanation of Benefits States
Service date 1- We bill $200.00 the insurance then states we are required to bill you as deductible $100.00 and write off the remainder. $100.00 comes out of your MyoFit Clinic account and gets applied to that date.

Service date 2 we billed $150.00 the insurance states we are required to bill you as deductible $75.00 and write off the remainder. The remaining $20.00 gets pulled from your MyoFit account and you would now be billed the remaining $55.00.

Moving forward we are requiring all patients that have an insurance contracted responsibility to make payment at each visit as agreed upon on your Insurance Acknowledgement form. This payment can be made by cash, check and credit card when signing in for your appointment. As an added convenience we also offer the option of putting a credit card on file. This will make the process even quicker for you and the receipt can be emailed directly to your email address. Your Credit card information would be saved in our secure Square Register system and be protected under Square security.

MyoFit Clinic staff would like to thank you for trusting us with your Physical Therapy needs. We value each and every one of our Clients. We will continue to provide you with the very best care and the respect you deserve.

Acknowledgement of Receipt of MyoFit Clinic Billing Overview

I acknowledge that I was provided a copy of the notice of MyoFit Clinic Billing Overview and that I have read (or had the opportunity to read if I so chose) and understand the notice.
Notices are posted in the waiting area or a written copy can be obtained at the front desk. *

Signature _____ Date _____

Relationship to Patient _____

Billing Policies

Below list an outline of the MyoFit Clinic Billing Policies. We ask that you reach out to your insurance and know your medical insurance benefits. When purchasing your insurance you entered into a contract and agreed to their terms of responsibility to medical providers. We have to abide by those terms as a medical practice as we too entered into an agreement to be contracted with the insurance company.

- As our patient, you are responsible for any referrals if needed to seek treatment in this office.
- We will accept VISA, Mastercard, cash or check as payment method
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment outside of the prepaid amounts.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay, coinsurance or deductible the Insurance assigns.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for the charges to any service rendered. Patients are encouraged to contact their plan for clarification of benefits prior to services rendered.
- You **must** inform the office of all insurance changes. In the event the office is not informed, you will be responsible for all charges denied in your explanation of benefits, please reference service date 2 above.
- For most services provided at MyoFit Clinic, we will bill your health plan. Any balance due is your responsibility.
- Past due accounts are subject to collection fees of 35%. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office. ***A portion of your medical records may be released to the agency upon non-payment.

**" There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Acknowledgement of Receipt of MyoFit Clinic Billing Policies

I acknowledge that I was provided a copy of the notice of MyoFit Clinic Billing Policies and that I have read (or had the opportunity to read if I so chose) and understand the notice.

Signature of Responsible Party _____ Date _____

Printed Name _____

Consents and Release of Information

By becoming a patient at MyoFit Clinic we will now become part of your healthcare team. We want to ensure you receive the best care possible and that your team stays in contact with each other. As part of your healthcare team we will communicate with your Primary Care Physician or Specialist regarding your diagnosis associated with your treatment with MyoFit Clinic.

Please list any providers you agree to let MyoFit clinic communicate with regarding your care.

_____ Phone Number: _____

_____ Phone Number: _____

_____ Phone Number: _____

Insurance companies may require from time to time we share your records with them for authorization and or payment review. By signing this form you agree to MyoFit Clinic communicating with your insurance company on your behalf.

Medical Record Release

I hereby authorize the release of any information by MyoFit Clinic to my physician and insurance company.

Signature of Responsible Party _____ Date_____

Printed Name _____ Relationship to Patient _____

Consent for Treatment

I do herby agree to give my consent for MyoFit Clinic to furnish medical care and treatment for

_____ considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature of Patient or Guardian: _____ Date: _____

Attendance Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and progression toward goals is something we at MyoFit Clinic take very seriously. Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress; therefore, we have certain rules that need to be followed to ensure the most optimum results. We expect you to keep all of your appointments. We will write down your appointment time and dates for you so you do not forget. If requested, reminders can be made the day before your scheduled appointment via: phone call, text or email.

With the exception of SERIOUS emergencies, it is expected that you will keep all of your appointments. IF YOU NEED TO RESCHEDULE AN APPOINTMENT, WE REQUIRE A 24 HOUR ADVANCED NOTICE. In such a case, please call our office to make arrangements for a make-up appointment in the same week. In the instance of a same day cancellation, we reserve the right to charge a $25.00 cancellation fee and an appointment that is considered a NO SHOW will be subject to a $35.00 fee.

In the instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care. We will inform your physician that our services have been discontinued due to noncompliance with prescribed rehabilitation orders.

In an effort to provide the highest standard of care to all of our patients and to protect privacy, we request that your children attend your therapy sessions only if absolutely necessary. During these times we kindly ask that you keep your child close to you at all times. MyoFit Clinic reserves the right to discontinue treatment should your child become disruptive, distracting, or their behavior exceeds your ability to monitor them. MyoFit Clinic is not responsible for any damages and not liable for any injury caused by your children.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you!!

I have read and understand the above policy.

Signature: _____ Date:_____

Witness: _____ Date: _____

Appointment Reminder Consent

Complete this form and sign below to give your permission for MyoFit Clinic to provide automatic appointment reminders. The option below will be the only way you receive appointment Confirmation.

Step One: Select an option below or can select all:

_____ **Phone Call Reminders**
Please list the number to receive the call.

_____

_____ **Email message**
Please list the email address you would receive the reminder.

_____

_____ **Text Message**
Please list the number to receive the text message.

_____

Signature of Patient or Guardian: _____

Date: _____