New Patient Intake

Patient Information

Name:_____

DOB: _____

Address: _____

City: _____ State:_____ Zip:_____

Primary Phone: _____ Secondary Number: _____

Ok to leave detailed message: YES NO Email:_____

Social Security Number: _____

Emergency Contact

Name:_____

Relationship:_____

Phone Number:_____

Employer

Name: _____ Phone #:_____

Address:_____

City, State, Zip:_____

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

(OVER)

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Relationship to Patient:_____

Signature: _____ Date: _____

Consent for Treatment

I do hereby agree to give my consent for MyoFit Clinic to furnish medical care and treatment the Doctor of Physical Therapy considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature of Patient or Guardian: _____ Date: _____

Printed Name:_____

Release Of Information

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

Signature of Responsible Party _____ Date_____

Printed Name _____ Relationship to Patient _____

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: _____

Name: _____ DOB: _____

Commitment to Therapy Services/Attendance Policy

Your commitment to your plan of care that your Doctor of Physical Therapy outlined for you is the number one determining factor in your success and outcome. A 100% commitment to the plan is a 100% commitment to yourself and your overall goals. Your Plan of Care and your goals have been outlined below. Success will not be achieved if you do not commit to your treatment plan and the below points. (Initial after each line as acknowledgment and agreement)

- ❑ I will attend all of my scheduled appointments to stay within my plan of care. _____
- ❑ If unable to attend a scheduled appointment I will reschedule 24 hours prior to appointment for another time within the same week to stay within my plan of care. _____
- ❑ I will complete as directed my Home Exercise Program per my plan of care. _____
- ❑ I will communicate at each visit with my therapist regarding my issues/pain. _____
- ❑ I will communicate with my therapist if I feel I am not getting the relief as expected so my treatment can be adjusted._____
- ❑ I understand that starting Physical Therapy can cause some discomfort but ultimately symptoms will improve. _____
- ❑ I understand there is a $25.00 cancellation fee if my appointment is not cancelled 24 hours in advance and a $35.00 fee for all NO CALL/NO SHOW appointments._____

With your 100% commitment and the skilled team of MyoFit Clinic on your side your Pain Free days are within reach.

Signature:_____ Date:_____

Scheduling Frequency

Frequency per week: 3 times 2 times

Signature: _____ Date:_____

Dr. Adam Cramer Dr. Adam Miller Dr. Celine Pollander Dr. Andrea Hulls Dr. Chrysta Blechschmid

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 _____