Intecore PHYSICAL THERAPY

Welcome to Intecore Physical Therapy, we are pleased to have you as a new patient, and are looking forward to taking care of all your physical therapy needs. Below is some information to help you achieve the most from your therapy visits.

WHAT TO BRING:

- Insurance card
- Driver's License
- Completed patient intake forms
- Prescription from doctor
- List of medications

- Please BE ON TIME to your appointments-Please call the clinic if you are going to be late.
- Please dress appropriately for physical therapy appointments and make sure that the affected joint can be easily exposed so that your therapist may better evaluate and/or work on the joint. We recommend shorts/sweats, t-shirts, workout clothing and athletic shoes.
- *Consistency*- In order for you to attain your rehabilitation goals it is necessary that you attend physical therapy consistently to ensure a timely recovery. It is important to make this physical therapy a priority to help you regain your prior level of function.
- *Please schedule your appointments* out for the duration of your prescription to ensure you get the most convenient times for you; we are a busy clinic and time slots fill up quickly.
- *Confirmation calls*- Automated confirmation calls are made prior to your physical therapy appointments. Due to circumstances beyond our control, you may not receive this reminder call, please do not rely on the confirmation call to remind you of your physical therapy appointment. We will provide you a print out of your schedule at your first visit and at any time you update your schedule.
- We are contracted with most major insurance companies and will bill the insurer directly. We also strive to meet the varying needs of our patients with flexible payment plans if that need arises. Our therapist are certified for direct access which allows us to treat without physician referral, this may not be covered by all insurance plans.

First Treatment: Your therapist will interview you, evaluate your condition, and establish and individualized treatment programs for you.

Future Treatments: The therapist may use methods such as therapeutic exercise, joint and soft tissue mobilization, electrical stimulation, heat/cold therapy and patient education. Future visits may include warm up exercises you have already learned, and will progress through the course of your rehabilitation.

Home Treatment: During the course of your rehabilitation, your therapist will prescribe a home exercise program to be carried out on your own. This is an important part of your treatment program, In most cases, two to three hours a week spent in physical therapy is not enough time to improve function.

We Value Your Business!

We understand that there are many choices for physical therapy treatment, and are proud to be able to offer you the best possible care available. If there are ever any concerns or questions before, during, or after your treatment, please do not hesitate to contact our staff immediately, whether in person, by phone, or email. We are continually working hard to be The Source for Health and Wellness in our Community! If you enjoyed your time with us -we encourage you to share your experience!

Intecore PHYSICAL THERAPY

NEW PATIENT FORM

PLEASE PRINT CLEARLY W/ BLACK INK

Date:_____

Name (Last) _____ (First) _____ (M.I.) _____

Birth Date_____ Social Security_____ Age _____Sex: M / F

Home Address_____

City_____ State_____ ZIP_____

Area to be treated_____ Date First Consulted_____ Injury Date _____

Home Phone (_____)_____ Work Phone (_____)_____ Other Phone (_____)_____

Email _____ How shall we contact you? (circle) Home Ph. / Cell Ph. / E-mail / Text

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Employment Full / Part-time / Not Working / Retired **Employer**_____

Emergency Contact_____Relation_____ Phone_____

Referring Physician_____ Telephone _____

How did you hear about us? ☐ Friend/Relative _____ ☐ Internet ☐ Yellow Pages ☐ Physician ☐ Other_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____ Is an attorney involved? Yes / No

Attorney name _____

Address _____ Telephone # (_____) _____

Patient Signature:_____**Date:**_____

(OFFICE USE ONLY)

MEDICAL HISTORY

Patient Name_____ Age_____

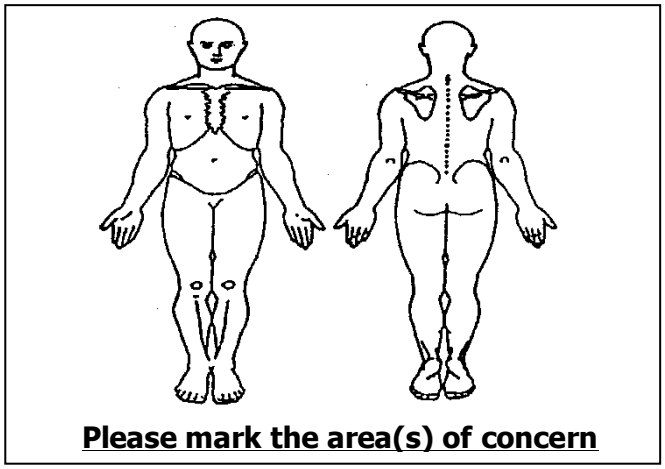
Type of Injury/Condition _____ Onset/Injury Date_____

Type of Surgery/Surgery Date_____

Next Doctor's Appointment_____

Have you received physical therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



Please mark the area(s) of concern

Have you had any imaging performed? :

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted any of the following?

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs When Walking
- ☐ Numbness / Tingling
- ☐ Change In Vision or Hearing
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Please explain & give approximate dates for any items indicated above_____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 / At its best: 1 2 3 4 5 6 7 8 9 10

How long have you had this pain? _____

What are your goals for treatment/physical therapy?_____

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____ _____

Patient or Personal Representative Signature **Date**

(For Intecore PT/OFFICE USE ONLY) 1/01/2021

Patient would benefit from: (☐ check all that apply)

- ☐ Bracing
- ☐ Graston/scraping
- ☐ Stretch Lab*
- ☐ KneeKG
- ☐ E-stim
- ☐ Laser*
- ☐ Foam roll
- ☐ Ultrasound
- ☐ Recovery Boot*
- ☐ Cupping
- ☐ Hypervolt
- ☐ Therx or Rehab Gym
- ☐ Manual only ($70)

*Not currently available

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize ***Intecore Physical Therapy*** to treat the minor patient named in the attached forms while I am not present. x_____
Initial

WORKERS' COMPENSATION CLAIMS: If you have a Workers' Compensation claim and benefits are subsequently denied, you and/or your employer may be held responsible for the total amount of charges for services rendered. x_____
Initial

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned agree and give my consent for ***Intecore Physical Therapy*** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

x_____
Initial

ASSIGNMENT OF INSURANCE BENEFITS: I authorize ***Intecore Physical Therapy*** to furnish information to insurance carriers concerning this treatment and I assign to Intecore all payment for services.

x_____
Initial

CANCELLATION & NO-SHOW POLICY: We require **24 hours notice** in the event of a cancellation. The charge for cancellation without proper notice is $75 for a physical therapy visit. This charge will not be covered by insurance and I will personally pay the charge **prior to receiving additional treatment**. x_____
Initial

PATIENT FINANCIAL OBLIGATION AND AGREEMENT - PATIENT MUST READ:

Intecore Physical Therapy will bill your personal insurance carrier solely as a courtesy to you. YOU ARE RESPONSIBLE FOR YOUR BILL. Per the contractual obligations we have with your insurance company, we are required to collect ALL payments at the time of treatment. x_____
Initial

If your insurance carrier does not remit payment to Intecore within 60 days, the balance owed will be due in-full. In the event that your insurance company requests a refund of payments made to *Intecore*, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by your insurance company or adjuster/attorney for physical therapy services provided by and billed by Intecore, you agree to promptly remit the payment(s) to *Intecore* directly. If formal collections procedures become necessary, you will be responsible for additional costs incurred. x_____
Initial

I UNDERSTAND THAT I AM RESPONSIBLE FOR VERIFYING MY OWN INSURANCE BENEFITS AND I AM AWARE OF PATIENT DEDUCTIBLES, CO-PAYS, CO-INSURANCE OR VISIT LIMITATIONS. I AGREE THAT I AM RESPONSIBLE FOR NOTIFYING *INTECORE* WHEN/IF MY INSURANCE PROVIDER OR BENEFITS CHANGE. IF I FAIL TO NOTIFY *INTECORE* OF THIS CHANGE, I AM RESPONSIBLE FOR ALL PAYMENTS. x_____
Initial

By signing below, I agree to the above PATIENT FINANCIAL RESPONSIBILITY, and I acknowledge that I have read and understand the above information. BY SIGNING, I AGREE THAT I AM PERSONALLY RESPONSIBLE FOR ALL PAYMENTS ON MY ACCOUNT FOR SERVICES PROVIDED BY ***INTECORE PHYSICAL THERAPY***.

Patient/Guardian Name (print) _____

Patient/Guardian Signature_____ **Date**_____

Clinic Representative _____ **Date**_____

24 HOUR CANCELLATION POLICY

To Our Patients Regarding Cancellations and No Shows:

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether or not you succeed in your treatment. You referring doctor or Therapist has prescribed a frequency of treatment and maintaining your scheduled visits is your highest priority.

- We require a 24-hour notice in the event of a cancellation. It is your responsibility, when you call, to have an alternate time in mind that will ensure you attend the entire number of prescribed treatments for each week.
- There is a $50 charge for a cancellation without proper notice. This charge is NOT covered by your insurance and will have to be paid by you personally.
- For worker's compensation and personal injury patients, documentation of any missed appointments will be forwarded to your Case Manager, and Primary Physician and this can jeopardize your claim.

In an instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, we reserve the right to charge a $75 fee.

1. After the 1st offense a credit card number will be requested, if not already on file, to collect the **$75** fee.
2. After the 2nd offense the fee will increase to our standard cash rate of **$100** and will remain for all subsequent infractions.
3. Cancellation and No-Show fees are to be paid prior to the following appointment. You may not be able to be treated until fees are paid.
4. In addition, 3 offenses without payment may result in the loss of your physical therapy benefits. We reserve the right to cancel all future appointments and withhold scheduling future appointments.

_____ (Patient Initial)_____(Staff Initial)

When you do not attend as scheduled, three people are being hurt by the action: 1) you--because you did not receive your treatment as prescribed; 2) the therapist—who scheduled the time for you, and your treatment; 3) another patient who could have been scheduled if proper notice was given.

Please co-operate with our Cancellation and No-Show policy; it benefits all. We are looking forward to working with you!

_____ _____

Patient (Guardian) Signature: Date:

Intecore
PHYSICAL THERAPY

Pre-Authorized Healthcare Form

I authorize ***Intecore Physical Therapy*** to keep my signature on file AND to charge my Visa/Mastercard/AmEx/other account as indicated below:

Check one: ____Mastercard _____Visa _____AmEx _____Other

Name on Card: _____

Credit Card # (last 4-digits): _____
(we are compliant with the law & your credit card information is encrypted and kept in a secure file)

Expires: _____ CVV Code: _____

☐ Balance of charges not paid by insurance within 90 days and not to exceed $_____

☐ Recurring changes (on-going treatments) of $_____ from _____ (date) to _____ (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice directly to Intecore Physical Therapy.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Address

_____
City State Zip

_____
Cardholder Signature Date

Form updated April 2019

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Date of Birth

_____

Social Security Number

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

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A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____

Signature of Authorized Clinic Representative Date