F&S Physical Therapy

Alma, Charleston, Fort Smith,
Mount Ida, and Waldron
WELLNESSPTCARE.COM

Wellness Physical Therapy

Patient Intake

Demographic Information:

Full Name (as it appears on your insurance card) _____ Preferred Name/Nickname _____

Street Address _____ City, State Zip _____ Phone # _____ Home Mobile _____

Email Address: We will use for sending home exercise program _____ Social Security Number _____

Date of Birth _____ Age _____ Gender _____ Marital Status _____ Preferred Language _____

Appointment Reminder Method: ☐ Text Message ☐ Phone Call ☐ Email ☐ No Reminder

Employer _____ Occupation _____ Working: Yes/No/Modified _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Information:

Primary Insurance Carrier _____ Responsible Party _____

(IF OTHER THAN SELF) Subscribers Name and address _____ Relationship _____ DOB _____ SS# _____

Secondary Insurance Carrier _____ Subscribers Name _____ Date of Birth _____ SS# _____

Referring Physician:

Name of Referring Physician _____ Physician Phone # _____

Date of next visit with referring physician _____ Primary Care Physician _____ Primary Care Phone # _____

PRINT Patient/Guardian Name _____ **SIGN** Patient/Guardian Name _____ Date _____

Patient Medical History

Patient Name _____ Height _____ Weight _____

Type of Injury/Condition _____ Date of Injury/Onset _____

(If Applicable) Type of Surgery/Procedure _____ Date of Surgery _____

Please describe your Physical limitations because of injury/surgery.

_____

Please describe any activities or movements that aggravate your symptoms.

_____

Please describe any treatments, movements or self-care that decrease your symptoms.

_____

Please list any previous injury, conditions, or surgeries.

Have you had any of the following diagnostic tests relating to this injury (Circle all that apply)

X-Ray MRI CT Scan Doppler Ultrasound Other: _____

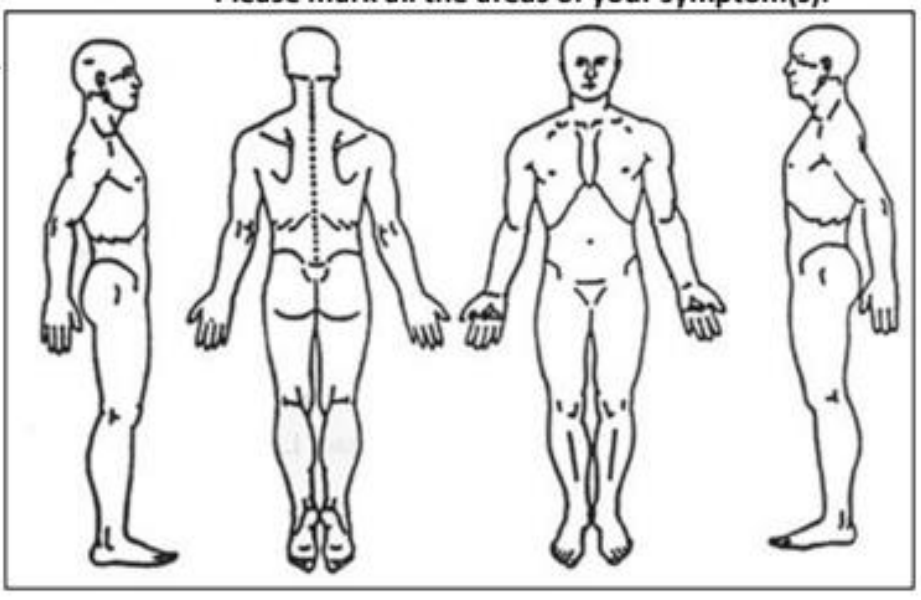
Which of the following describes your pain? (Circle all that apply)

Sharp Achy Burning Tingling Numbness Other: _____

Please rate your pain: (0 = none, 5 = moderate, 10 = severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10

Please mark all the areas of your symptom(s):



Fall History:

Is your injury the result of a fall? Yes or No Date of fall: _____

Have you fallen twice or more in the past year? Yes or No

Health Habits and Lifestyle:

Do you eat a well-balanced diet? Yes or No Do you drink water regularly? Yes or No

Do you smoke? Yes or No Daily amount: _____ For how long? _____

Do you Drink alcohol? Yes or No #/day_____ Days/Week? _____

Do you exercise regularly? Yes or No How often? _____ Type/program? _____

Do you have any hobbies/leisure activities? Yes or No Type: _____

Treatment History:

Have you ever been treated for this condition? By whom? _____

Was it helpful? Yes or No Please explain: _____

What are your goals for Physical Therapy? _____

What do you hope to get out of your treatment? _____

Please list any important dates such as return to sport/big performance/games coming up that you want to be ready to participate:

_____

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

_____

Is this a Workers Compensation Case? Yes or No

Is this a Motor Vehicle Accident Case? Yes or No

Medical History: Have you been diagnosed with any of the following conditions:

Allergies	Y	N	Diabetes	Y	N	Metal implants	Y	N
Anemia	Y	N	Dizziness/Vertigo	Y	N	Multiple Sclerosis	Y	N
Anxiety	Y	N	Emphysema/COPD	Y	N	Neurological disorder	Y	N
Arthritis	Y	N	Fibromyalgia/Fatigue	Y	N	Numbness/tingling	Y	N
Asthma	Y	N	Fractures	Y	N	Osteoporosis/Osteopenia	Y	N
Bladder/Bowel problems	Y	N	Gastrointestinal Problems	Y	N	Pain Syndromes/CRPS	Y	N
Cancer	Y	N	Gallbladder Problems	Y	N	Parkinson's	Y	N
Cardiac Disease	Y	N	Headache/Migraines	Y	N	Seizures	Y	N
Cardiac pacemaker	Y	N	Hepatitis	Y	N	Speech Problems	Y	N
Defibrillator	Y	N	Hernia	Y	N	Strokes	Y	N
Circulation problems	Y	N	High blood pressure	Y	N	Thyroid Problems	Y	N
Currently Pregnant	Y	N	Incontinence	Y	N	Vision Problems	Y	N
Depression	Y	N	Kidney Problems	Y	N			

Commitment to Physical Therapy

Late, No-Show, Cancellation and Rescheduling Policies
Payment and Insurance Policy

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we feel it is our duty to do everything within our power to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

Commitment to your appointments

- With the exception of serious emergencies, your recovery depends upon attending all your appointments.
- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible.
- Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. We will inform your physician of the fact that your service has been discontinued due to noncompliance with the prescribed rehabilitation order.

Late Policy

- If you are less than 15 minutes late and have contacted F&S/Wellness Physical Therapy to warn us that you'll be late, you may complete the remaining time scheduled for your session, knowing that you will not receive a full session.
- If you are more than 15 minutes late and have not contacted F&S/Wellness Physical Therapy, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a $25 fee.

No-Show Policy

- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you $25 no-show fee.
- Reminder Calls: While we offer automated reminder calls as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS. If reminder calls do not go out, and you do not show up for your appointment, you may still be charged the $25 no-show fee.

Cancellation Policy

- If you need to reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment.
- Late Cancel: If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $25 cancellation fee.

Re-Schedule Policy

- If you need to cancel a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment.
- Late Reschedule: If you try to reschedule an appointment within 24 hours of your appointment this is considered a Late Reschedule and we reserve the right to charge you a $25 cancellation fee unless:
    - You reschedule your appointment to later the same day (if there is time available). OR
    - We are able to fill your vacated slot with another client.

Paying, Cancellation, and No-Show Fees

- Cancellation and No-Show fees are not billable to any form of insurance.
- To resume treatment following a late cancel, late reschedule, or no-show, the $25 fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to turn your care back to your referring physician.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation.

PRINT Patient/Guardian Name	**SIGN** Patient/Guardian Name	Date

FINANCIAL POLICY:

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, co-insurance, and deductibles at the time of each visit. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month.

PATIENT'S RESPONSIBILTY:

- It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status.
- Understand their insurance policy, and to ask questions when they don't.
- Covered Benefits: As a courtesy to our patients, we will verify and file your claim with your insurance carrier; however, we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Physical/Occupational Therapy services.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurances, and/or deductibles at time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescription for physical therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days previous to their 1st visit.

INSURANCE PATIENTS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize F&S/Wellness Physical Therapy to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to F&S/Wellness Physical Therapy _____ (Initial)

MEDICARE PATIENTS:
Have you had any PT this year provided in your home or in another outpatient clinic? Yes or No _____ # of visits.

Do you currently have Medicare home services? Yes or No _____ (Initial)

SELF PAY PATIENTS: For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. _____ (Initial)

VOLUNTARY TERMINATION OF TREATMENT: It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. _____ (Initial)

HIPPA NOTIFICATION:
Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, F&S/Wellness Physical Therapy is required to provide you with a copy of this notice which is available at the front desk. _____ (Initial)

I have read the above information and I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____ _____

PRINT Patient/Guardian Name **SIGN** Patient/Guardian Name Date