CHECKLIST FOR YOUR FIRST VISIT

You're ready for your first visit when you have the following:

- ☐ **Medical Prescription (Not required however recommended for post operative patients)**
- ☐ **Referral from primary care physician (If Needed)**
  - A medical prescription is a script written from the doctor prescribing the services needed, like the slip given to the pharmacist when filling a prescription for medication
  - A referral is different. This is an insurance company form filled out by and obtained from your primary care physician's office that allows you to be seen, so services will be reimbursed and not denied upon claim submission. If you are not sure you need one, ask our staff.
- ☐ **Medical History (Any pertinent test results or films you feel will help your therapist accurately diagnose and treat your condition)**
- ☐ **Loose fitting clothing**
- ☐ **Co-payment (If applicable, it is a payment due at the time services are rendered. It is in fulfillment of the contract you have with your insurance company. It can be satisfied with either cash, check, or major credit card)**
- ☐ **Insurance Card**
- ☐ **You have confirmed your appointment time and are prepared to arrive 10-15 minutes early to process the administrative aspect of your visit.**

PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name:	E-Mail:		SS#: / /
Address:	City:	State:	Zip Code:
Telephone: H: C:	Date of Birth: / /	Sex: (circle one) M | F	Date of Injury: / /

How would you like to be reminded of your appointments (MUST CHOOSE ONE): ❑ E-Mail (provide email above) ❑ Phone Call: #______________________ ❑ Text Message: #______________________

Auto Related? ❑ Yes - State: _____ ❑ No	If Auto Accident: Date of Accident: / / Type of Accident (circle one): Driver | Passenger | Pedestrian
Work Related? ❑ Yes - State: _____ ❑ No	If Workers Comp, was accident with present employer? ❑ Yes ❑ No If No, who was employer: ________________
Are you currently receiving Home Health Services? ❑ Yes ❑ No	If Yes, name of agency and what type of services? ____________________ If No, have you received services in the past 60 days? ❑Yes ❑No

Were you ever treated for outpatient physical therapy before? ❑ Yes ❑ No

PRIMARY INSURANCE INFORMATION

Insurance Company:	Policy or Claim #:	Group #:
Policy Holder Name:	Date of Birth: (mm/dd/yy) / /	SS#: / /
Insurance Company Telephone:	Policy Holders Work Phone:	Holder: ❑ Self ❑ Spouse ❑ Dependant ❑ Other ________

SECONDARY INSURANCE INFORMATION ❑ Not Applicable (Backup if Auto, Workers Comp. or Litigation)

Insurance Company:	Policy or Claim #:	Group #:
Policy Holder Name:	Date of Birth: (mm/dd/yy) / /	SS#: / /
Insurance Company Telephone:	Policy Holders Work Phone:	Holder: ❑ Self ❑ Spouse ❑ Dependant ❑ Other ________

EMPLOYER INFORMATION:

Employer Name:	Employer Phone #:	Status: ❑ FT ❑ PT ❑ Retired ❑ Self ❑ Student ❑ Other _____
Address:	City / State:	Zip Code:

EMERGENCY CONTACT INFORMATION:

Contact Name:	Phone:	Relationship: ❑ Parent ❑ Spouse ❑ Sibling ❑ Other: ________

PHYSICIAN INFORMATION:

Name of referring Physician:	Phone:

I ____, authorize JointCare Physical Therapy to release my insurance company/ Lawyer/ Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Signature:____ **Date:** ________________________________

JointCare
Physical Therapy
& Fitness Center

MEDICAL INTAKE QUESTIONAIRE

Name: ______________________________ **Date:** ______________

Date of Surgery / Accident: ______________________ **Age:** ______________

1. History of heart problems	YES / NO	details: ______________
2. Pace-Maker	YES / NO	details: ______________
3. High Blood Pressure	YES / NO	details: ______________
4. Cancer	YES / NO	details: ______________
5. Tumors or cysts removed	YES / NO	details: ______________
6. Tuberculosis	YES / NO	details: ______________
7. Skin Disorders	YES / NO	details: ______________
8. HIV Positive	YES / NO	details: ______________
9. Lung Disease	YES / NO	details: ______________
10. Asthma	YES / NO	details: ______________
11. Are you currently pregnant	YES / NO	details: ______________
12. Headaches	YES / NO	details: ______________
13. Dizziness	YES / NO	details: ______________
14. Blurred vision	YES / NO	details: ______________
15. Vomiting or nausea	YES / NO	details: ______________
16. Numbness	YES / NO	details: ______________
17. Arthritis	YES / NO	details: ______________
18. Osteoporosis	YES / NO	details: ______________
19. Internal implants (metal or plastic)	YES / NO	details: ______________
20. Diabetes	YES / NO	details: ______________
21. Hepatitis A / B / C	YES / NO	details: ______________
22. Circulation problems	YES / NO	details: ______________
23. Sensitivity to heat or ice packs	YES / NO	details: ______________

24. Other____

____

25. **Current Medications:** ____

26. **Occupation:** ______________________ **Currently Working:** ❑ **YES** ❑ **NO** ❑ **Light Duty**

27. **Circle a percentage you feel you are functioning at due to this injury:**
(0% = severely restricted and 100% = no restriction.)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

28. **Circle a number you feel your pain is:**
(0 = no pain and 10 = emergency room pain)

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**

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give consent for JointCare Physical Therapy, LLC to furnish care and treatment to ***(patient)*** ____ that is considered necessary and proper in diagnosing or treating my/his/her condition.

Notice of Privacy Practices

As per HIPPA guidelines, I acknowledge that I have read and understand the notice of Privacy Practices for JointCare Physical Therapy, LLC, and may be furnished with a copy upon my request.

Benefit Assignment

I hereby assign medical benefits to which I am entitled, including Medicare, private insurance, and third party payors, to JointCare Physical Therapy, LLC. A photocopy of this assignment is to be considered as valid as the original.

Financial Policy Statement

If any payment is made directly to me for services billed by JointCare Physical Therapy, LLC, I recognize an obligation to promptly remit that amount along with any explanations of payment to JointCare Physical Therapy, LLC. I understand agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed including original charges, interest, collection agency fees, and attorney fees.

Billing and Benefits

It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We will bill your insurance carrier as ***a courtesy to you*** in cooperation with ***Advanced Medical Billing Solutions, INC***. We have called your insurance carrier for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

Estimated coverage information is provided as a courtesy to our patients and is not intended to release them from total responsibility of treatment/payment. *Please be aware that this is not a guarantee of benefits.* Actual plan benefits can only be determined upon receipt and processing of your claims.
(Federal Regulation Code 29, Section 2560.503-1).

Worker's Compensation Clause

The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At that time, our Financial Policy will apply to you.

I have read the above information and understand my responsibilities.

____
Patient's Name **(PRINT)**

____
Patient / Guardian Signature Date

____
Witness / Employee Signature Date

24 HOUR CANCELLATION & 15 MINUTE LATE POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our office takes quite seriously.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results. As a courtesy, we will furnish you appointment lists specifying your appointment dates and times.

LATE: If you feel that you may be late for a scheduled appointment, please contact our Administrative Staff. Arriving 15 minutes after your scheduled appointment time may prevent us from providing you with a full treatment session. We will make every effort to care for you but rescheduling the appointment may be necessary.

CANCEL: With the exception of serious emergencies it is expected that you keep all your appointments. However, if you need to cancel an appointment we require 24 hours notice. In such a case, please call our Administrative Staff and arrange for a make-up appointment within the same week of the canceled appointment.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you choosing us as your healthcare provider and look forward to working with you to achieve your goals.

JointCare Physical Therapy

I have read and understand this policy:

Signature: ______________________________________ Date: ______________

MEDICARE UPDATE

Attention Medicare Patients ONLY:

Effective January 1st, 2010 Medicare has placed a financial limit of $1860.00 per beneficiary on physical and speech therapy (combined) for services during the calendar year. This cap does not include therapy performed and billed at an outpatient hospital setting or as part of Medicare covered home health care services. Medicare patients are responsible for 100% of the provider charges above the respective limit or after reaching this limit, can continue physical therapy at an outpatient hospital setting. Medicare will allow exceptions to this limit based on medical necessity as defined and approved by Medicare. Further information regarding this policy is in the 2010 beneficiary handbook. Additional information is available at (800) 633-4227. If you have any further questions, please don't hesitate to ask.

Signature:____ Date:____________