PRESIDIO
Sport & Medicine

PATIENT INTAKE FORM

PLEASE PRINT CLEARLY

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

Home Address_____

City_____ State_____ Zip_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

Date of Birth_____ **Gender** ☐ M ☐ F **Marital Status** ☐ Single ☐ Married ☐ Other

Social Security #_____ **Email Address***_____

** We send monthly newsletters about physical therapy, health, and fitness and would love to include you. We will <u>not</u> sell or give away your information to third parties.*

☐ *I would like to opt out of the newsletter mailing list, but may receive messages regarding my account.*

Appointment Confirmation Method *(please only select one)*

☐ Phone call ☐ Email ☐ Text (_____)_____ ☐ No reminders please, I know my appointments

How did you hear about Presidio Sport & Medicine? ☐ Friend _____ ☐ I'm a returning client

☐ Yelp ☐ Doctor_____ ☐ Other_____

Primary Subscriber on Insurance ☐ Self ☐ Spouse ☐ Dependent ☐ Other_____

If Primary Subscriber is <u>other than Self</u>, Primary Subscriber Name_____

Primary Subscriber Date of Birth_____ Primary Subscriber Phone (_____)_____ Gender ☐ M ☐ F

Employment Status ☐ Employed ☐ Part-Time Student ☐ Full-Time Student ☐ Other

Employer_____ Occupation_____

Emergency Contact_____ Relation_____ Phone (_____)_____

Referring Doctor_____ Phone (_____)_____

Injury Type ☐ Work ☐ Auto ☐ Other_____ Injury Date_____ Surgery Date_____

Attorney Involved ☐ No ☐ Yes If Yes, Attorney Name_____

Address _____ Phone (_____)_____

Patient Signature _____ **Date** _____

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MEDICAL HISTORY

Name_____ Age_____

Type of Condition / Injury_____ Onset / Injury Date_____

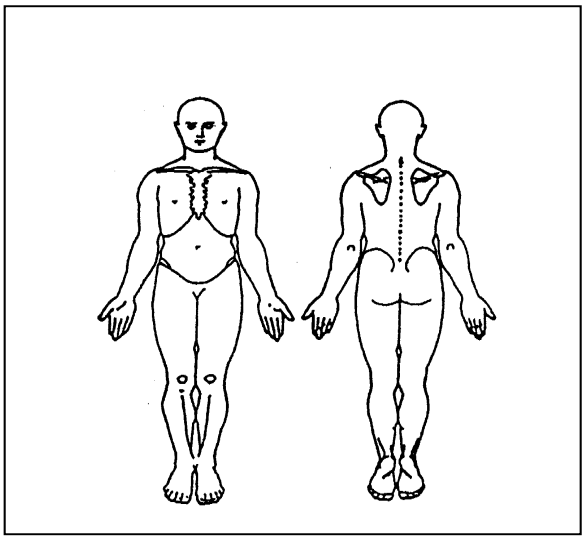
Type of Surgery & Date _____

Referring Doctor _____

Next Doctor's Appointment _____

Describe previous treatment for this condition_____

_____



Please mark the area(s) of concern

Have you had any imaging performed:

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

Have you recently noted any of the following:

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

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 condition that may affect current care_____

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

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

_____

What are your current physical or fitness goals?_____

_____

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

Patient Signature _____ **Date** _____

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Medication List

Date: ___________________

Patient Name: ____ Date of Birth: ________________________________

INSTRUCTIONS: Please list ALL medications you are taking. Include prescription drugs, over-the-counter drugs, herbals, and vitamin/mineral/dietary [nutritional] supplements.

Medication	Dosage	Frequency	Route
			☐ By mouth ☐ Injection ☐ Other: __________________
			☐ By mouth ☐ Injection ☐ Other: __________________
			☐ By mouth ☐ Injection ☐ Other: __________________
			☐ By mouth ☐ Injection ☐ Other:__________________
			☐ By mouth ☐ Injection ☐ Other:__________________
			☐ By mouth ☐ Injection ☐ Other:__________________
			☐ By mouth ☐ Injection ☐ Other:__________________
			☐ By mouth ☐ Injection ☐ Other:__________________
			☐ By mouth ☐ Injection ☐ Other:__________________
			☐ By mouth ☐ Injection ☐ Other:__________________

Reviewed by: ______________________________

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OFFICE POLICY

CONSENT FOR CARE

(FOR ADULTS ONLY) I hereby agree and give my consent for Presidio Sport & Medicine to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ ***(initial)***

(FOR MINORS ONLY) As parent and/or legal guardian, I authorize Presidio Sport & Medicine to treat the patient named herein while I am not present. _____ ***(parent/guardian initial)***

ASSIGNMENT OF FINANCIAL RESPONSIBILITY

(FOR INSURANCE PATIENTS ONLY) **ASSIGNMENT OF BENEFITS:** I hereby authorize **Presidio Sport & Medicine** to furnish information to my insurance carrier(s) concerning treatment and I hereby assign all payment for services rendered to Presidio Sport & Medicine. _____ ***(initial)***

(FOR INSURANCE PATIENTS ONLY) **FINANCIAL POLICY:** You are responsible for knowing your benefit information. If we are billing your insurance company, we will assist you to the best of our ability with getting your claims paid. However, if any charges are not covered by your insurance plan, you are financially responsible. What we collect in the office may only be a ***portion*** of your balance. Actual financial obligation can only be determined once your insurance company has processed a claim. You are ultimately financially responsible for all services rendered to you. If your account is deferred to a collection agency, you agree to pay all collection costs incurred. _____ ***(initial)***

(FOR SELF PAY PATIENTS ONLY) **ASSIGNMENT OF BENEFITS:** I do not have insurance that Presidio Sport & Medicine is contracted with, so elect for self-pay rates which must be paid at the time of service. _____ ***(initial)***

PAYMENT POLICIES

LATE ARRIVALS: Arriving 15 or more minutes late to a physical therapy visit will be considered a no-show and will be subject to a fee of $50. Arriving 30 or more minutes late to an evaluation will be considered a no-show and will be subject to a fee of $125 _____ **(initial)**

CANCELLATION POLICY: Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours' notice so we can better reallocate the time to someone else in need of treatment. **Appointments cancelled with less than 24-hours' notice or not shown up for will be charged a fee** (to the card listed below) **of $125 for an evaluation, $50 for physical therapy.** This fee is not covered by insurance. If you late cancel or no show more than three times, then you may be subject to additional cancellation policies. _____ **(initial)**

Name as it appears on card: _____

Card Number: _____ Exp. Date: _____ Security code: _____

SERVICE POLICY (Please select one):

☐ **PAYMENT AT THE TIME OF SERVICE** *(recommended for self-pay patients and insurance plans with flat copays)*
I agree to pay for my estimated portion upon check-in each time I am seen. If I do not pay for my estimated portion at the time services are rendered, I authorize Presidio Sport & Medicine to charge the following credit card.

☐ **MONTHLY PAYMENT** *(recommended **only** for insurance plans with deductible and/or coinsurance responsibilities)*
I authorize Presidio Sport & Medicine to charge the following credit card after the close of each month for all outstanding balances.

Use the same credit card for cancellations and services rendered? ☐ Yes ☐ No (if No, complete alternative card below)

Name as it appears on card: _____

Card Number: _____ Exp. Date: _____ Security code: _____

☐ *This is an HSA/FSA card*

I have read the above information and *I understand the responsibility for the payment of my account*.

Patient Signature _____ **Date** _____

(Parent/Guardian, if patient is a minor)

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HIPAA NOTIFICATION

Notice of Privacy Practices for Protected Health Information
Health Insurance Portability & Accountability Act of 1996 (HIPAA)

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, Presidio Sport & Medicine is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either electronically or on paper.

Please Select One:

☐ **Waiver (Receive HIPAA Electronically)**

I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice. I am aware that this Notice is available to me online at Presidio Sport & Medicine's website, www.presidiosport.com, and I choose to receive such Notice electronically. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

OR

☐ **Acknowledgement (Receive HIPAA Paper Copy)**

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____