Pasadena Physical Therapy, PC
Patient Intake Form

Patient Information

Please Select ☐ Private Insurance ☐ Medicare ☐ Self-Pay ☐ Worker's Compensation

Last Name ___________________________ First Name _________________________________ Middle Initial ____

Address ___________________________________ City _________________________ State ____ Zip __________

Phone # ____________________________ ☐ Home ☐ Cell E-mail _______________________________________

Emergency Contact ____ Phone # ____________________________

DOB _____________ SS # _________________ Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment

Employment Status ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Not Working ☐ Retired ☐ Student

Occupation ____________________________ Employer Name ____

Address ___________________________________ City _________________________ State ____ Zip __________

Phone # _____________________________

Referral

Referring Physician ____ Date of Last MD Visit _____________

Phone # _____________________________ Fax # _____________________________

Diagnosis ____ Prescribed Frequency & Duration __________________

Primary Care Physician ____ Same as Referring Physician? Yes No

Who else may we thank for your referral? Yelp Google Word of Mouth Other ____________________________

Injury

Area(s) of Injury ____

Is this a: ☐ Work Injury ☐ Auto Injury ☐ Sports Injury? Date of Injury ________________

Is this post-surgical? ☐ Yes ☐ No Date of Surgery ________________

Is there an Attorney involved? ☐ Yes ☐ No If Yes – **STOP!** We do not take cases where an Attorney is involved.

Have you had physical therapy services earlier this calendar year? Yes No

If Yes, where at ____ And for how many visits? _____

Medicare ONLY – Additional Questions

Are you currently: Receiving Home Health Services? Yes No Residing in a Skilled Nursing Facility (SNF)? Yes No

Have you received Physical, Occupational, or Speech Therapy services during this calendar year? Yes No

If "Yes", do you know if you have exceeded your Medicare Therapy Cap amount? Yes No

Pasadena Physical Therapy, PC
Patient Medical History Form

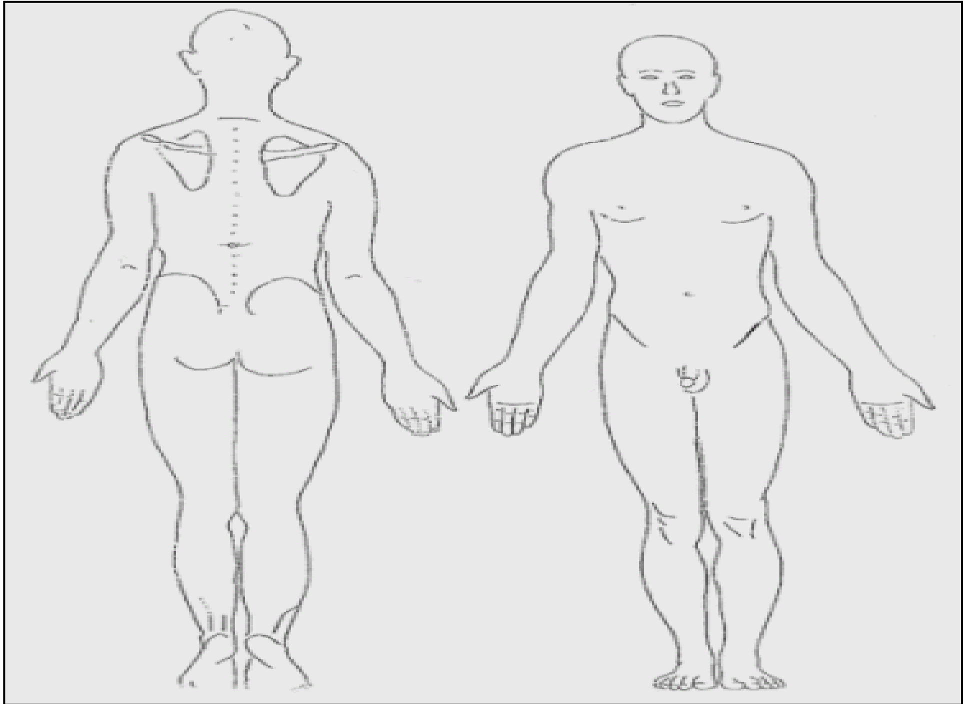
Patient Name ____ **DOB** _______________

To you, what are the most important things your Physical Therapist can help you with?

1. ____
2. ____
3. ____

Please rate the function of your affected body part(s): _____%
(Where 100% = normal)

(PT Notes)



Please mark the area(s) of concern

Have you had a recent: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG Study ☐ Other: ______________________

Do you currently have, or have ever had any of the following? (Please circle)

Abdominal Surgery | Allergies | Arthritis | Asthma | Cancer | Circulatory Conditions |
Depression | Diabetes | Fractures | Heart Disease | High Blood Pressure | Metal Implants
Pain at Night | Osteoporosis | Pacemaker | Seizures | Weight Change (Sudden, Significant)

During the **Past Month**, have you been bothered by:

☐ Feeling down, depressed, or hopeless?
☐ Having little interest or feeling little pleasure in doing things?

Have you noticed a change in your vision or hearing? NO YES
(Females) Do you suspect that you may be pregnant? NO YES

I affirm that the above information is accurate & true to the best of my knowledge.

________________________________ ________________________________ ____________
Patient or Parent/Legal Guardian Name (PRINT) Patient or Parent/Legal Guardian (Signature) Date

Pasadena Physical Therapy, PC
Office Policies

PLEASE READ CAREFULLY & INITIAL

Consent for Care & Treatment

— I do hereby consent to rehabilitation & related services at Pasadena Physical Therapy, PC (hereafter "PPT"). In doing so, I understand that there are no guarantees as to the result of the treatment(s) I may receive. I have been given the opportunity to ask questions & my questions have been answered to my satisfaction.

Assignment of Insurance Medical Benefits | Insurance Verification Disclaimer | Financial Responsibility

— I assign all insurance medical benefits, to which I am entitled, to PPT, & request that payment of benefits be made on my behalf to PPT for any services provided to me. I authorize & instruct my insurance company to pay by EFT or by check & by mail directly to:

Pasadena Physical Therapy, PC
95 W. California Blvd.
Pasadena, CA 91105

PPT will obtain a quote of benefits as a courtesy to our patients & we are, at no time, to be held responsible for incorrect information that has been provided by your insurance company. We provide you with a summary of your benefits & not a guarantee of payment. Eligibility & benefits will be determined at the time your claims are processed. The deductible & copayment due is an approximation of the amount you are responsible for based on your insurance coverage.

— I shall be financially responsible for any & all charges that are not covered by my insurance company.

Missed Visit (Late Cancellation & No-Show) Policy

— I understand that a specific time slot is reserved for me when I schedule an appointment, & I accept full responsibility for my scheduled appointments. I understand that PPT does offer a 1-time exemption for legitimate reasons (e.g., illness, emergency).

— If I am unable to keep my scheduled appointment, I will provide PPT at least 24 hours notice so that PPT may reschedule my appointment & offer that time slot to another patient in need of physical therapy services.

— PPT's Missed Visit fee is **$115** (the self-pay rate for a follow-up visit). I understand that this fee is not covered by insurance & that I will be personally responsible for any Missed Visit fees.

— ***(Worker's Compensation Only)*** I understand that PPT is required to report any Missed Visits to my Worker's Compensation Adjuster or Nurse/Case Manager. I understand that it is PPT's policy to discharge any Worker's Compensation patient that accumulates two (2) Missed Visits, and that being discharged from physical therapy for poor attendance may affect the outcome of my Worker's Compensation claim.

Medicare Only – Coverage Limits

Medicare limits coverage for rehabilitation services to a certain dollar amount per calendar year. This includes physical therapy ("PT"), occupational therapy, speech therapy, home health physical therapy ("HHPT"), & chiropractic treatment, combined. Therefore, it is critical that you provide us an accurate number of visits you have made to other providers for these services in this calendar year, & whether or not they are still on-going. This will allow us to verify the number of visits that Medicare will allow for PT at PPT. Medicare does not cover for PT provided by PPT where the patient is also receiving HHPT. Accordingly, please answer the following:

— The information I have provided on Page 1 under "Medicare Only" is accurate & complete.

— I currently am NOT receiving home health physical therapy.

— I will keep PPT informed of all additional rehabilitation service visits.

— I will be financially responsible to PPT for any visits that are not covered by Medicare to the extent that I did not inform PPT, in writing, of outside rehabilitation service visits.

Consent for Treatment of a Minor

— As parent and/or legal guardian, I authorize PPT to treat the minor patient named below while I am not present.

Patient or Parent/Legal Guardian Name (PRINT)	Patient or Parent/Legal Guardian (Signature)	Date