# *PATIENT INTAKE FORM*

Today's Date ______________ Referring Doctor _______________________________

HOW DID YOU HEAR ABOUT US? Please Circle and Fill In:

1. Doctor ______________ 2. Friend / Family ______________

3. Internet/Google _____________ 4. Previous Pt 5. Other ____________

**1. Patient's Last Name**___________________________ First___________________ MI_____

Address_______________________________________________________________________

City__________________________________ State__________ Zip Code_______________

Home #___________________________ Work #_________________ Ext._____________

Cell #____________________________ May we leave a message?___________________

Email Address_________________________________________________________________

SS#___________________ DOB_______________ Age_________ Sex: M or F

Emergency Contact Person____________________ Phone # ______________________

**2. Name of Patient's Employer**___________________________________________________

Employer Address_______________________________________________________________

City_______________________________ State__________ Zip Code ________________

Occupation____________________________________________________________________

**3. Parent's Information** (if patient is under the age of 18)

Last Name______________________________ First_______________________ MI______

Address (If different from above) _______________________________________________

City_______________________________ State__________ Zip Code_________________

Home # __________________________ Work #_____________________ Ext.____________

DOB_____________________________ SS#______________________________________

4. **Primary Insurance Company**______________________________________

ID # ___________________________ Group #_______________________

Are you the subscriber? Y or N If NO, name of subscriber_______________

Patient's relationship to subscriber___________________________________

SS# (of subscriber)__________________ DOB (of subscriber)_____________

5. **Secondary Insurance Company**___________________________________

ID#_________________________ Group #_________________________

Are you the subscriber? Y or N If NO, name of subscriber_______________

Patient's relationship to subscriber__________________________________

SS# (of subscriber)_________________ DOB (of subscriber)_____________

6. **Date of Injury** (if applicable) _______________________________________

Nature/Type of Injury_____________________________________________

7. **Auto Insurance** (if injury was due to automobile accident)

Auto Insurance Co._____________________ Name of Insured_____________

Address______________________________________________________

City______________________ State_______________ Zip Code__________

Policy #_________________________ Claim #______________________

Adjustor's Name________________________ Phone #__________________

8. **Worker's Compensation** (if work related injury)

Are we a panel provider?__________________________________________

Name of Employer (at time of injury)__________________________________

Worker's Comp. Insurance Co.______________________________________

Address______________________________________________________

City________________________ State_____________ Zip Code__________

Claim #_______________________________________________________

Adjustor's Name________________________ Phone #__________________

# *Notice of Privacy Practices*

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

By law, Fritz Physical Therapy & Sports Medicine, P.L.L.C is required to protect the privacy of your personal medical information. Fritz Physical Therapy & Sports Medicine, P.L.L.C is also required to give you this notice to tell you how Fritz Physical Therapy & Sports Medicine, P.L.L.C may use and give out ("disclose") your personal medical information held by Fritz Physical Therapy & Sports Medicine, P.L.L.C.

Fritz Physical Therapy & Sports Medicine, P.L.L.C **must** use and give out your personal medical information to provide information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

Fritz Physical Therapy & Sports Medicine, P.L.L.C **may** use or give out your personal medical information for the following purposes under limited circumstances:

- To State and other Federal agencies that have the legal right to receive Fritz Physical Therapy & Sports Medicine, P.L.L.C data (such as to make sure Fritz Physical Therapy & Sports Medicine, P.L.L.C is making proper payments and to assist Federal/State Medicaid programs),
- For public health activities (such as reporting disease outbreaks),
- For government health care oversight activities (such as fraud and abuse investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and imminent threat to your or anothers health or safety,
- To contact you about new or changed benefits under Fritz Physical Therapy & Sports Medicine, P.L.L.C, and
- To create a collection of information that can no longer be traced back to you.
- To doctors, nurses and other professionals involved in your care to inform them of relevant symptoms, response(s) to treatments, etc, to insure successful delivery of physical therapy/fitness services.
- To insurance company(s) or other parties identified by you for purposes of payment of services. Information will be used to prepare invoices, bills, statements, etc.
- To individuals identified by you as being approved to view, hear, discuss private health information regarding billing, care given, etc.
- We may use your information to contact you in an effort to schedule appointments, discuss billing issues and inform you of relevant services which may be of interest to you. You may request a specific avenue of contact (i.e. email, etc)

By law, Fritz Physical Therapy & Sports Medicine, P.L.L.C must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if Fritz Physical Therapy & Sports Medicine, P.L.L.C has already acted based on your permission.

By law, you have the right to:

- See and get a copy of your personal medical information held by Fritz Physical Therapy & Sports Medicine, P.L.L.C.
- Have your personal medical information amended if you believe that it is wrong or if information is missing, and Fritz Physical Therapy & Sports Medicine, P.L.L.C agrees. If Fritz Physical Therapy & Sports Medicine, P.L.L.C disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from Fritz Physical Therapy & Sports Medicine, P.L.L.C. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Fritz Physical Therapy & Sports Medicine, P.L.L.C operations, or that was given out for law enforcement purposes.
- Ask Fritz Physical Therapy & Sports Medicine, P.L.L.C to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask Fritz Physical Therapy & Sports Medicine, P.L.L.C to limit how your personal medical information is used and given out to pay your claims and run the Fritz Physical Therapy & Sports Medicine, P.L.L.C program. Please note that Fritz Physical Therapy & Sports Medicine, P.L.L.C may not be able to agree to your request.
- Get a separate paper copy of this notice.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa or contact the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Fritz Physical Therapy & Sports Medicine, P.L.L.C is required to follow the terms in this privacy notice. Fritz Physical Therapy & Sports Medicine, P.L.L.C has the right to change the way your personal medical information is used and given out. If Fritz Physical Therapy & Sports Medicine, P.L.L.C makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

________________________________________ ______________
Patient (Guardian) Signature Date

# *Consent to Bill/Treat*
# *Financial Responsibility*

We must have your authorization to submit a claim for payment for services covered under your insurance policy to your insurance carrier. Please complete and sign below.

I ________________________ authorize Fritz Physical Therapy & Sports Medicine,L.L.C to submit a claim(s) to my insurance carrier or its intermediaries for all services rendered and authorized and direct my insurance carrier or its intermediaries to issue payment(s) directly to Fritz Physical Therapy & Sports Medicine, P.L.L.C.

I _______________________ consent to have physical therapy/fitness treatment and care prescribed by my physician and provided by Fritz Physical Therapy & Sports Medicine,.L.L.C. I am aware that I can question the therapist concerning any and all matters relating to my care at any time. I am aware that I am not required to attend prescribed sessions, however it is highly recommended.

I _______________________ understand that I am financially responsible for, and will be billed for, all balances remaining on my account which are unpaid by my insurance carrier (i.e. co-pays, co-insurance, deductibles, etc.). I am aware that while Fritz Physical Therapy & Sports Medicine L.L.C will verify coverage(s) on my behalf, I am solely responsible for knowing and understanding my insurance plan coverage for physical therapy services.

_____________________________________ ____________

Patient (guardian) Signature Date

# *Authorized Individuals*

At times, it may be necessary for an individual other than yourself to contact Fritz Physical Therapy & Sports Medicine, P.L.L.C to discuss your personal health information or to make inquires concerning billing, scheduling, etc. Please indicate any individuals whom you authorize for us to discuss your treatment or personal health information.

Name: Relationship:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

***I authorize Fritz Physical Therapy & Sports Medicine, L.L.C to disclose personal health information regarding treatment, billing or other services related to my current condition to the above individuals.***

_________________________________ _________________

Patient (Guardian) Signature Date

## Past Medical History Form

Patient Name:____________________ Date:_________________

Please answer the following questions to the best of your ability:

Date of your last medical physical exam: _________________

Please List any medications you currently are taking:

______________________________________________________________________________

______________________________________________________________________________

Any Recent Surgeries or hospitalizations? Yes/No; If Yes, please describe:

______________________________________________________________________________

______________________________________________________________________________

Do you participate in any regular exercise or sport program? Yes/No
Are you, or could you be pregnant? Yes/No

Do you have, or have had, any of the following conditions:

Heart Attack ____________________ Yes/No

High Blood Pressure ____________________ Yes/No

Heart disease ____________________ Yes/No

Heart Murmur/Palpitations ____________________ Yes/No

Pacemaker ____________________ Yes/No

Kidney Disease ____________________ Yes/No

Cancer ____________________ Yes/No

Breathing Disorders (COPD, Asthma, etc) ____________________ Yes/No

Smoking ____________________ Yes/No

Allergies ____________________ Yes/No

Liver Disease ____________________ Yes/No

Neurological Disease (Stroke, Parkinson’s, epilepsy, etc) ____________________ Yes/No

Diabetes ____________________ Yes/No

Rheumatoid Arthritis ____________________ Yes/No

Hernia ____________________ Yes/No

Autism Spectrum Disorder ____________________ Yes/No

Osteoporosis____________________ Yes/No

Please Describe Your Current Symptoms:

When/How did your symptoms begin?

______________________________________________________________________

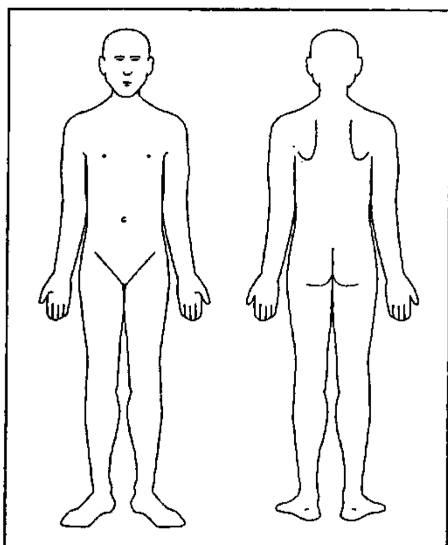
______________________________________________________________________

Have you experienced these symptoms in the past? Yes/No
If Yes, briefly describe any previous treatments:

______________________________________________________________________

______________________________________________________________________

Please mark the location of your pain below, using the key provided:



Sharp/Stabbing: /////////
Burning: xxxxxxxxx
Numbness/Pins & Needles: ooooooo
Dull Ache: =======

My Symptoms are best described as:

_______ Constant: never goes away
_______ Intermittent: relieved with positioning/rest
_______Occasional: Daily or less frequent
________Variable: sometimes worse than others

My Symptoms are:

_______ Getting Worse
_______ Getting Better

Rank your pain over the last 24 hours on a scale of 0 – 10, 0 being no pain, 10 being the worst pain you have ever felt.

Best: ______
Worst: ______
Current: ______