BIG ROCK PHYSICAL THERAPY
PATIENT INTAKE INFORMATION

1. **May we utilize text messages for your appointment reminders?**

YES **NO**

By selecting 'yes' above, you understand that text message communications may NOT be secure, with a risk of unauthorized access to your information.

2. **May we send you emails relating to your care with us?**

YES **NO** **N/A**

Email: _____

By providing your email address above, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

3. **Do you currently have, or have you ever had:**

A workers compensation case/claim

An attorney due to an auto or employment injury

Or any other situation

That could affect the billing of your physical therapy treatments?

YES **NO**

******If the answer is yes, STOP! - WE NEED MORE INFORMATION!******

Are you currently receiving, or have you received in the past 60 days:

Home Health Services: YES NO **Physical Therapy Services: YES NO**

In the next 60 days are you scheduled to receive physical therapy anywhere other than at *Big Rock Physical Therapy?* YES NO

EMERGENCY CONTACT		
Name	**Relationship to you**	**Contact Number**

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: BIG ROCK PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**_____

LIABILITY

I know and agree that: BIG ROCK PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: BIG ROCK PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:**_____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: BIG ROCK PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:**_____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:**_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:**_____
I acknowledge receipt of the Statement of Patient Rights. **Initials:**_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

Cancellation Policy/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five ($25) fee; this will not be covered by your insurance company.

Scheduled Appointments:

We understand that delays can happen, however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we reserve the right to reschedule the appointment.**

Print Name: _____

Patient Signature: _____

Date: _____

Medical History Form

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Do you smoke or use tobacco? ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ Allergies ☐ Latex ☐ Other	☐ Dizziness	☐ Kidney Problems
☐ Anemia	☐ Epilepsy or Seizure Disorder	☐ Metal Implants
☐ Anxiety or Panic Disorders	☐ Fainting	☐ MRSA
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness	☐ Multiple Sclerosis
☐ Asthma	☐ Fever or Chills	☐ Nausea / Vomiting
☐ Blood Thinners	☐ Fractures	☐ Osteoporosis
☐ Bowel or Bladder Disorder	☐ Headaches	☐ Pacemaker
☐ Bleeding Disorder	☐ Head Injury or Concussion	☐ Parkinson's Disease
☐ Cancer	☐ Hearing Impairment	☐ Peripheral Vascular Disease
☐ Chronic Cough	☐ Heart Disease or Heart Attack	☐ Respiratory or Breathing Problems
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Ringing in Ears
☐ Congestive Heart Failure	☐ Hernia	☐ Sexual Dysfunction
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low	☐ Skin Abnormalities
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS	☐ Stroke or TIA
☐ Depression	☐ Hypoglycemia	☐ Thyroid Problems
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity to Hot or Cold	☐ Tuberculosis

List any other medical problems and explain:

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine: ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Medication List

Name of Medication	Dosage	Frequency	Route
1			☐ Injection ☐ Oral ☐ Topical ☐ Other
2			☐ Injection ☐ Oral ☐ Topical ☐ Other
3			☐ Injection ☐ Oral ☐ Topical ☐ Other
4			☐ Injection ☐ Oral ☐ Topical ☐ Other
5			☐ Injection ☐ Oral ☐ Topical ☐ Other
6			☐ Injection ☐ Oral ☐ Topical ☐ Other
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other
8.			☐ Injection ☐ Oral ☐ Topical ☐ Other
9.			☐ Injection ☐ Oral ☐ Topical ☐ Other
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name	Relationship

Name	Relationship

Signature of Patient **Date**