BACK COUNTRY PHYSICAL THERAPY INTAKE FORM

PLEASE FILL OUT OUR INTAKE FORM. WE UNDERSTAND HOW PAINFUL PAPERWORK IS, SO FEEL FREE TO ASK US QUESTIONS OR IF YOU NEED ANY ASSISTANCE.

Patient Information:

Name: _____ Social Security #: _____
Sex (Circle): M / F

Address:_____City:_____
State: _____Zip: _____

Home Phone: _____Birth date: _____ Age: _____

Marital Status (Circle): S / M / D / W

Employer: _____Full time / Part time
Work Phone: _____

Injured area: _____

Referring Physician:
_____

If a minor, name of responsible party:
_____

How did you learn about this facility? Check all that apply:
☐ Physician ☐ Insurance Company ☐ Telephone Book ☐ Newspaper ☐ Website
☐ You are a Former Patient ☐ Family/Friend
☐ Other (please specify) _____

☐ **Bill Me Personally**

☐ **Primary Insurance Information:**

Relationship to patient: _____

Birth date of insured: _____Insured Social Security#_____
Employer: _____

Insurance Name: _____
Insurance Phone:_____

BACK COUNTRY PHYSICAL THERAPY INTAKE FORM

Insurance Address:

_____

_____

Policy #: _____

Group Number:_____

☐ **Secondary Insurance Information:**

Policy Holders Name: _____

Relationship to patient: _____

Birth date of insured: _____Insured Social Security#_____

Employer: _____

Insurance Name: _____

Insurance Phone:_____

Insurance Address:

_____

_____

Policy #: _____

Group Number:_____

Workman's Compensation:

Employer where injury occurred:_____

Case Manager and phone #: _____/_____

Case #:_____

Have you had any physical therapy visits with this claim? Y / N

Auto accident:

Claim Number: _____

Insurance: _____

Insurance Address:

_____

Attorney's Name: _____ Phone #:_____

Current History:

What date (approximately) did your present symptoms start, or date of surgery?

_____

Do you know how it happened? (Chronic condition / Don't know how it happened / New injury)

_____

Surgery Performed: Y N If so when:_____

Prior Hospitalization: Y N If so when:_____

How have your symptoms changed? Improving about the same getting worse

How has this affected your life?_____

Describe your current symptoms:_____

Have you had symptoms like this in the past? Y N

If you have had symptoms like this before; when?_____

If you have had symptoms like this before; how many episodes?_____

On the scale below, circle the **BEST and WORST** level of pain you have experienced over the last week:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Circle the number below which best represents your **current** level of pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

What makes your symptoms better?

_____

_____

What makes your symptoms worse?

_____

_____

Circle yes **(Y)** or no **(N)** for what makes your symptoms **worse**:

Bending:	Y	N
Sitting:	Y	N
Turning:	Y	N
Rising:	Y	N
Standing:	Y	N
Walking:	Y	N
Lying:	Y	N
In AM:	Y	N
During day:	Y	N
In PM:	Y	N
When Still:	Y	N

How would you rate your health: Good / Fair / Poor

Are you employed? Y N

If so, what do you do?_____

Circle what position you are in most of the day? sitting / standing / moving around

Please answer yes or no if you have any of these conditions:

Alzheimer's	Yes	No	History of Cancer	Yes	No
Cardiovascular Disease	Yes	No	Huntington's	Yes	No
Groin Numbness	Yes	No	Immunosuppression	Yes	No
Stroke	Yes	No	Lupus	Yes	No
Current Infection	Yes	No	Muscular Dystrophy	Yes	No
Diabetes Type 1	Yes	No	Obesity	Yes	No
Diabetes Type 2	Yes	No	Osteoarthritis	Yes	No
Fibromyalgia	Yes	No	Parkinson's	Yes	No
Suspected Fracture	Yes	No	Rheumatoid Arthritis	Yes	No
High Blood Pressure	Yes	No	Traumatic Brain Injury	Yes	No
Hepatitis B or C	Yes	No	Other _____		

Have you had an X-ray, MRI, or other testing for your current condition? No / Yes (specify)

_____

_____

Allergies:_____

List any other treatments you have received for this injury/condition including physical therapy:

_____

_____

Medications:_____

_____

Past Surgeries:_____

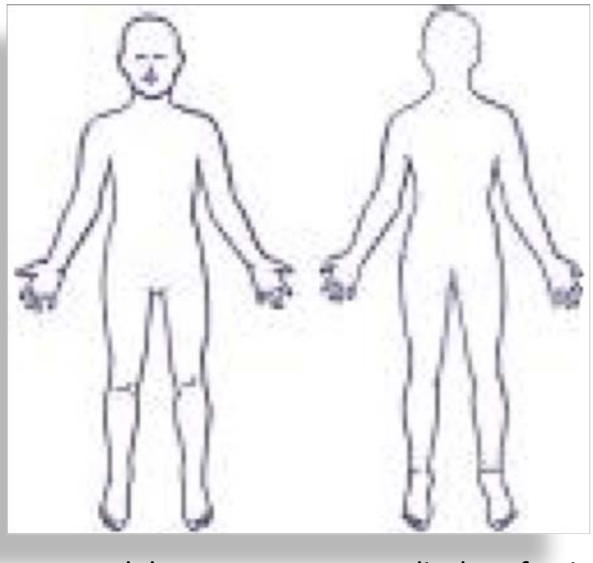
_____

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance	**Unexplained** weight loss	Falls-In last 6 months
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night pain	Headaches

For Women: Are you pregnant or think you might be pregnant? ____Yes ____No

Body Chart:



Mark where you feel your symptoms:

During the past month have you seen a medical professional: Yes / No If yes, please describe the medical professional and reason:_____

REFERRAL (PRESCRIPTION):

Many insurance companies allow you to see a physical therapist without a physician referral. However, you must follow up with your physician before any continued sessions after 30 days or 12 visits from the start of your first physical therapy visit. However some insurance companies require a physician's referral for physical therapy treatment for reimbursement. It is your responsibility to contact your insurance company to find out if they pay for physical therapy services.

MEDICARE / WORKERS' COMPENSATION PATIENTS:

Medicare and Workers' Compensation will not pay for a physical therapy visit unless the patient has seen their referring physician within 30 days of that visit. Please let us know when you see your doctor. If Medicare or Workers' Compensation does not pay for your physical therapy because you have not seen the doctor within 30 days of the physical therapy visit, the charges for service will be your responsibility. If Workers' Compensation or auto insurance exhausts or refuses to pay, then your private insurance will be billed, or you directly.

GUARANTEE OF PAYMENT:

I guarantee payment for all services provided by Back Country Physical Therapy, LLC. I understand that I am financially responsible for all charges including, but not limited to, all co-payments, deductibles, and expenses not covered or paid by insurance. I authorize Back Country Physical Therapy, LLC to bill my health insurance for services rendered. All payments received will be applied to my balance. It is my responsibility to provide Back Country Physical Therapy, LLC with complete and accurate insurance information in order for them to bill. I will also provide any other special requirements by the insurance company. The requirements may include but are not limited to, referrals from primary care physician, accident information, or pre-authorization from the ordering doctor. I agree to pay reasonable finance charges, attorney fees and any additional fees if my account becomes delinquent and if it becomes necessary to turn my account over to a collection agency. I understand that copays will be paid at the time of service. Although Back Country Physical Therapy, LLC will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold Back Country Physical Therapy, LLC, responsible for any misinterpretation of insurance benefits. I understand that a 24 hour notice is required before cancelling my appointment. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

Signature _____ Date _____

AGREEMENT FOR RELEASE OF INFORMATION/HIPPA:

Permission is hereby granted to Back Country Physical Therapy, LLC to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Back Country Physical Therapy, LLC.

Signature _____ Date _____

CONSENT FOR TREATMENT:

I acknowledge that all information provided above is accurate to the best of my knowledge. I have read and agree to all terms and conditions noted throughout this application and give my consent to be evaluated and treated by Back Country Physical Therapy, LLC.

Signature _____ Date _____

Congratulations! You Survived!

◯ Patient was offered a copy of signed agreement Including "Guarantee of Payment, Agreement For Release of Information, and Consent for Treatment" but patient declined.

◯ Patient was given a copy of signed agreement Including "Guarantee of Payment, Agreement For Release of Information, and Consent for Treatment."