TRI-PRO
PHYSICAL THERAPY

Patient Intake Form

Basic Information

Date _____ DOB_____ Gender _____ Marital Status _____
Name (Last)_____(First)_____
Street Address _____
City _____ State _____ Zip Code _____
Referral _____

Contact Information

Home # _____ Cell # _____
Work Number # _____
Email Address _____
Emergency Contact
Name _____ Relationship _____
Emergency Phone # _____

Additional Information

Home Health Care [Yes] \ [No] Agency _____ D/C Date _____
RX [Yes] \ [No] Diagnosis _____ RX Date _____
Surgery [Yes] \ [No] If yes, what kind _____ Date _____
Referring MD _____ MD Phone # _____
Availability For Scheduling _____

Insurance Information

Primary Insurance Carrier _____
ID _____
Secondary Insurance Carrier _____
ID _____
Workers Compensation/ Auto Insurance_____
Claim # _____
Case Manager _____ Case Manager # _____

For Office Only:

Confirmed IE date/time:_____ Confirmed by:_____
Employee Initials _____
Insurance verification sent by : _____
NOTES: _____
_____
_____

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Physical Therapy Attendance Policy

Tri-Pro Physical Therapy strives to provide the highest quality of care while attempting to accommodate each client's schedule. Therefore, we provide each client a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery. While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and no shows can reduce our ability to accommodate the scheduling needs of our clients. As such, we request your full cooperation with the following company policy.

- If a client is more than 15 minutes late for an appointment and fails to notify the physical therapist of the tardiness, treatment may be cancelled and a cancellation fee of $25 will be charged on the 3rd occurrence (and subsequent occurrences) for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a cancellation fee of $25 will be charged on the 3rd occurrence (and subsequent occurrences) for that appointment.
- Failure to show up for a scheduled appointment without providing the physical therapist advance notification of your absence will result in a $25 fee charged for that appointment.
- Furthermore 3 consecutive absences without advanced notification may result in the cancellation of all your remaining scheduled appointments as such failures may negatively impact your treatment plan
- All additional fees must be paid before care can be rendered.
- All cancellations and absences will be documented in your medical record. Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which will require you to call for an appointment on the day you would like to receive therapy.

By signing below, I acknowledge that I have read the foregoing company policy and agree to its terms.

_____ _____

Patient/Guardian Acknowledgement/Signature. Date

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Financial Responsibility

I agree to pay Tri-Pro Physical Therapy all amounts that are due and owing for services provided, which are not otherwise paid for by a third party payor, or other payor source on my behalf for services rendered. In the event that this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, attorney's fees. I understand that I am responsible for any balance due and owing Tri-Pro Physical Therapy before services rendered. I agree to pay all amounts prior to initiation of treatment and services.

I understand and agree to the following financial terms:

I will pay a co-pay of $_____ at the start of each therapy session.

My deductible is $_____.

I will pay $_____towards my deductible at the start of each therapy session.

I agree to the self pay rate of $_____ for initial evaluation and $_____ for follow-up visits at the start of each therapy session.

My primary insurance is responsible for_____. My Co-insurance rate is responsible for _____.

I am aware of the following Insurance specific information
Authorization is required yes / no (Circle one)
Allotted therapy visits per year _____
Visits used year to date_____

By signing below, I acknowledge that I understand details of my insurance, my financial responsibility and agree to pay the terms that are listed above.

_____ _____
Patient/Guardian Acknowledgement/Signature. Date

Patient Consent

I have a condition requiring medical care. I hereby consent and authorize the administration of care, which may include, but is not limited to, performance of all examinations and to receive physical therapy services and any ancillary services such that my healthcare practitioners caring for me deem appropriate.
I further hereby consent to, and authorize Tri-Pro Physical Therapy to use and disclose my medical information consistent with the Notice of Privacy Practices. I further authorize and consent to the release of my medical information and my personal information (including but not limited to my home phone, cell phone, work phone, and address) to Tri-Pro Physical Therapy and the providers responsible for my care (and vendors they may utilize) as needed to facilitate the interpretation of test results;
account billing and collection; payment posting and or processing; or other related Healthcare functions.
I authorize Tri-Pro Physical Therapy and the providers who have provided care along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology.
I authorize Tri-Pro Physical Therapy access to my medical information to any person or organization for the coordination of care, treatment or services or for other purposes described above.
I have the right to consent, or otherwise refuse consent, to any proposed diagnostic testing, treatment procedure or therapeutic course.

I hereby refuse to consent to the above terms. No treatment will be performed.

_____ _____
Patient/Guardian Acknowledgement/Signature. Date

By signing below, I acknowledge that I have read the above consent and agree to be treated based on the terms listed above.

_____ _____
Patient/Guardian Acknowledgement/Signature. Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that all staff and employees of Tri-Pro Physical therapy are compliant with Health Insurance Portability and Accountability Act (HIPPA). I have been provided with a Notice of Privacy Practices, which provides a description of how my protected health information may be used or disclosed; and the Guide to Understanding Health Information Organizations.
I have read this for (or have had it read to me) and have had all my questions answered. I am satisfied that I understand the significance of its content and agree to its terms.

I acknowledge that Tri-Pro Physical Therapy Group may disclose protected health information for the purpose of payment, treatment, healthcare operations, address workers' compensation, law enforcement and other government request and to respond to lawsuits and legal action.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions

_____Checking this box indicates that the formal office **HIPAA policy and procedures** have been explained to the above noted client and the copy of the policy is provided to the
client.

Patient Valuables

I understand that Tri- Pro Physical Therapy group shall not be responsible for any of my personal property or any artificial devices including, but not limited to eyeglasses, cell phones, electronic devices.

By signing below, I acknowledge that I have read and understand the HIPPA policy and I am aware that I am responsible for my valuables.

_____ _____
Patient/Guardian Acknowledgement/Signature Date

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Media Consent

In conjunction with my care, I consent to allow the use of filming devices, such as cameras or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmission of such filming device images or video to Tri-Pro Physical Therapy and or treating providers through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that Tri-Pro physical therapy will not further use or disclose such film or images for any other purpose without my authorization or consent.

_____Yes/ No

In an ongoing effort to provide our clients with great customer service and the latest information regarding all of our client services, you may periodically receive emails from our company and its affiliates. If you prefer NOT to get these emails, please check the box below.

_____Yes, please send me updates through email/newsletter.

_____Opt out of Email/Newsletter

_____ _____

Patient/Guardian/ Acknowledgement/Signature. Date

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Parental/Guardian/Caregiver Consent Form

I declare that I am the parent/legal guardian/caregiver of _____ (Patient Name) and I authorize Tri-Pro Physical therapy to render services to said patient named above. I understand that I am responsible for understanding and signing of all consents and company policies

Parent/ Guardian/Caregiver Name: _____
Date of Birth _____
Y/N Address same as patient
If No, _____

Parent/Guardian/Caregiver Signature: _____

Relationship to patient: _____

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Fall Risk Assessment

Please mark "yes" or "no"

	Yes	No
Have you fallen in the past year? If yes, how many times?_____		
Have any falls resulted in an injury?		
Are you afraid of falling?		
Have you recently felt unsteady on your feet?		
Do you experience dizziness or vertigo?		
Do you have any vision problem not corrected by glasses?		
Do you use sedatives that affect your level of alertness during the day?		
Do you have memory or cognitive difficulties?		
Do you have any lower extremity difficulties affecting your walking?		

(Patient is considered a fall risk is fallen 2 or more times in a year, has fallen once resulting in an injury this past year, or has answered " yes" to 3 more of the above questions.)

_____ _____
Patient/Guardian Acknowledgement/Signature. Date

Medical history and medication reviewed with patient by:

Therapist (name and license number) _____

Past Medical History Form

Exercise Frequency: _____ Exercise Type(s): _____
Do you smoke? _____ Have you ever smoked? _____ How often?_____
Are you pregnant? _____ Do you have a Pacemaker?_____
Allergies: _____
What medication are you currently using? _____
Previous complaints/ surgeries:_____
Previous diagnosis/ medications: _____

What is your major complaint? _____
Start Date: _____ Possible cause? _____
Symptoms: _____
Previous doctors seen for complaint: _____
Previous treatment for complaint: _____
Symptom-Aggravating Factors:
_____
Symptom- Relieving Factors: _____
Time of day symptoms are best? _____ Time they are worst _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Is pain getting better or worse? _____Have you had this injury before? _____

☐ No known significant hx
☐ History of Cancer
☐ Alzheimer
☐ Asthma
☐ Blood Clots
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ Cerebral Vascular Accident
☐ Diabetes Type 1 or Type 2
☐ Fibromyalgia
☐ Fracture or suspected fracture
☐ High/Low Blood Pressure
☐ Immunosuppression
☐ Multiple Sclerosis
☐ Muscular dystrophy
☐ Obesity
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Traumatic Brain Injury
☐ OTHER _____
_____

_____ _____
Patient/Guardian/ Acknowledgement/Signature. Date

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Hold Harmless and Release Regarding COVID-19

Covid 19- Information

Covid-19 is a contagious virus that spreads from person to person. In addition to our regular cleaning policies and procedures that our office has in place, additional preventive measures are being followed to further reduce the spread of this novel coronavirus. However, please know that these best practices still offer no guarantee and there is a potential risk of exposure.

I acknowledge the existence of the COVID-19 virus, the dangers of the virus and the potential exposure to the virus that occur as a result of entering into Tri-Pro Physical Therapy.

As a patient/employee, I represent myself, each member of my respective household and immediate family, to the best of my knowledge, have not tested positive or shown signs of COVID-19, have not been in contact with any person in the past 14 days who has tested positive for COVID-19 or is waiting for results of a test for COVID-19, and have not within the last 14 days arrived from or been in contact with someone who has travelled abroad. I agree to immediately notify verbally and in writing if there are any changes within my episode of care.

Consent to our services

I understand that our services include physical touch and close proximity over an extended period of time. Because of this, there may be elevated risk of disease exposure, including COVID- 19. By signing this form, I acknowledge that I am aware of the risks involved from receiving service/ and or being employed at Tri-Pro Physical Therapy at this time. I voluntarily agree to assume those risks, and I release Tri- Pro Physical Therapy from any and all claims related to receiving services. I give my consent to receive service from Tri-Pro Physical Therapy.

I agree that I hold harmless, release and indemnify Tri-Pro Physical Therapy LLC and its members for any exposure to or a lawsuit or other claim by anyone as a result of the COVID-19 virus causing injury, illness or other damages arising from entering Tri-Pro Physical Therapy.

_____ _____

Signature Date

_____ _____

Print Name Witness Signature