

PATIENT INTAKE AND CONSENT FORM

Attachment B1.003A
Attachment M7.005C

Internal Use Only: A/C# Name A/C Type Office#

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex M F Marital Status S M D W

Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Responsible Party _____ Cell Phone _____

Address _____ E-mail _____

City _____ Injury Area _____

Phone Number _____ Accident Related: Yes No

Relationship to Responsible Party _____ If Accident: Auto Work Other

Nature of Accident _____

Employer _____ SS# _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No

(Continued on next page)

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

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CONSENT TO TREATMENT: I consent to rehabilitation and related services at ProCare... In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

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.

LIABILITY: I know and agree that ProCare... is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit ProCare... representatives, affiliates, employees, or assigns, of and from any and all liability, claim, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to... or allow emergency and or medical services, including but not limited to ambulance & Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

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

Patient/Guardian Signature _____ Witness Signature _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of ProCare... This form must be completed in its entirety and be provided to ProCare... prior to initiation of therapy services.

Confidential Medical History/Evaluation



Date: _____

How did you hear about ProCare? _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____ M/F Age: _____

DOB: ____/____/____ SS#: ____-____-____ Home phone#: _____ Cell phone#: _____

Address: _____ City: _____ State: _____ ZipCode: _____

Marital status: _____ Email address: _____

Employer: _____ Occupation: _____

Employer address: _____ Work phone#: _____

Insurance Subscriber Information (Person whom insurance is through)

Name: _____ DOB: ____/____/____

Employer: _____ Patient's relationship to subscriber: Self Spouse Child Other _____

Emergency Contact

Name: _____ Relationship to patient: _____ Phone #: _____

Have you received **Home Health** treatment for this or any other condition in this calendar year? YES ___ NO ___

If YES- what agency provided the services and for how long were you seen? _____

Is this condition the result of a work related injury? Y N

Is this condition related to an auto accident? Y N

Is this condition related to a motorcycle accident? Y N

Is this condition related to a personal accident? Y N

Is this condition the result of a school athletic injury? Y N

If yes, in which state did the accident occur? _____

If yes, in which state did the accident occur? _____

If yes, in which state did the accident occur? _____

If yes, in which state did the accident occur? _____

If yes, in which state did the accident occur? _____

If yes to any of the above, have you retained an attorney? Y N

Attorney Name _____

Address _____

City _____ State _____ Zip _____

Phone number _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to ProCare PT, LP. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred equaling 25% of my balance due.

Patient/parent/guardian signature: _____

Date: _____

Reviewed by _____

Patient Name _____

Medical History

Referring Physician: _____ Primary Care Physician: _____

Date of Symptoms or Injury: ____/____/____ Date of Surgery: ____/____/____

Area of injury/condition: _____

Chief Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking: _____

Are you allergic to any medications? _____

Past surgeries: _____

Have you had any diagnostic or rehabilitative services for this injury (MRI, x-ray, etc): _____

Wear glasses / contacts? YES NO _____

Have you fallen in the past year? YES NO If yes, how many times: _____

If yes to falling, did you sustain an injury as a result of the fall? YES NO _____

Do you currently have any "flu-type" symptoms (i.e. fever, coughing)? YES NO If yes, what symptoms: _____

Do you have any open cuts, lesions or wounds? YES NO If yes, where: _____

Do you have any of the following? Pain when performing the following activities?

	YES	NO	Mild	Mod	Severe	Unable
Asthma, bronchitis, or emphysema.....	_____	_____	_____	_____	_____	_____
Shortness of breath/chest pain.....	_____	_____	_____	_____	_____	_____
Coronary heart disease.....	_____	_____	_____	_____	_____	_____
Do you have a pacemaker.....	_____	_____	_____	_____	_____	_____
High blood pressure.....	_____	_____	_____	_____	_____	_____
Heart attack/heart surgery.....	_____	_____	_____	_____	_____	_____
Stroke/TIA.....	_____	_____	_____	_____	_____	_____
Blood clot/emboli.....	_____	_____	_____	_____	_____	_____
Epilepsy/seizures.....	_____	_____	_____	_____	_____	_____
Thyroid trouble/goiter.....	_____	_____	_____	_____	_____	_____
Anemia.....	_____	_____	_____	_____	_____	_____
Infectious disease.....	_____	_____	_____	_____	_____	_____
Diabetes.....	_____	_____	_____	_____	_____	_____
Cancer or chemo/radiation.....	_____	_____	_____	_____	_____	_____
Arthritis/swollen joints.....	_____	_____	_____	_____	_____	_____
Osteoporosis.....	_____	_____	_____	_____	_____	_____
Varicose veins.....	_____	_____	_____	_____	_____	_____
Gout.....	_____	_____	_____	_____	_____	_____
Sleeping difficulties.....	_____	_____	_____	_____	_____	_____
Emotional/psychological problems.....	_____	_____	_____	_____	_____	_____
Bowel or bladder problems.....	_____	_____	_____	_____	_____	_____
Severe/frequent headaches.....	_____	_____	_____	_____	_____	_____
Vision/hearing difficulties.....	_____	_____	_____	_____	_____	_____
Dizziness or faintness.....	_____	_____	_____	_____	_____	_____
Are you pregnant?.....	_____	_____	_____	_____	_____	_____
Smoking Daily _____ Weekly _____						
Alcohol consumption Daily _____ Weekly _____						

Other Medical Conditions _____

Are you aware of your diagnosis? YES _____ NO _____

Are you aware of your prognosis? YES _____ NO _____

Have you had Physical/Occupational Therapy, Speech Therapy OR Chiropractic treatment for this or any other injury/condition within the past year? YES _____ (please list # of visits and which therapy _____) NO _____

Therapist Signature _____ Date _____



ProCare PT, LP.

Headquarters: 310 Penn St, Suite 103 Hollidaysburg, PA 16648

Consent for Disclosure of PHI

I consent to the use and disclosure of my protected health information (PHI) by ProCare PT, LP. (ProCare) for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for the practice of ProCare. I understand that treatment of me by ProCare may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. ProCare is not required to agree to the restrictions that I may request. However, if they agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ProCare has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physical or occupational therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice’s Notice of Privacy Practices prior to signing this document. The practice’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the practice. The Notice of Privacy Practices for the practice is also provided at the front desk and in the waiting room. This Notice of Privacy Practices also describes my rights and the practice’s duties with respect to my PHI.

ProCare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting one in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority