Patient Intake

HAND & PHYSICAL THERAPY of Wyoming

Date: _____

First Name:_____ **Last Name:**_____ **Middle Initial:**____

Date of Birth:_____ **Last 4 of Social Security (VA /Tricare Only):** _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home #:_____ **Work #:**_____ **Cell #:**_____

How would you like to receive your statements? You can choose more than one option:

☐ **Mail** ☐ **Text Message** ☐ **Email (required for Patient Portal Access)**

Appt Reminders ☐ **Text Mobile #**_____ **Email:** _____

Gender: M or F Marital Status: (circle one) Single Married Divorced Widowed

Emergency Contact:_____ **Phone #:**_____

Relationship to Patient:_____

Referring Physician:_____

Primary Physician:_____

Billing Agreement

I understand I am financially responsible for all charges not covered by my insurance secondary to waivers or termination of my policy. Additionally, you will be charged a $45.00 No Show Fee if there is not a call within 24 hours of scheduled appointment.

Signed: (Patient or Parent of Minor):_____

Date and Time:_____

- I do not have Insurance and would like to discuss Self Pay options.
- Is this a Work-Related Injury? **(If YES- Please Complete Workman's Comp Intake Form**)

Primary Insurance:

Insurance Carrier: _____ Policy Number: _____

Group Number: _____

Policy Holder (if other than patient):_____Policy Holders DOB:_____

Social Security of Policy Holder (Only Required for VA and Tricare): _____

Secondary Insurance:

Insurance Carrier: _____ Policy Number: _____

Group Number: _____

Policy Holder (if other than patient):_____Policy Holders DOB:_____

Social Security of Policy Holder (Only Required for VA and Tricare): _____

Disclosure of Medical Records:

Hand and Physical Therapy of Wyoming, LP is committed to insuring the privacy and confidentiality of your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA). To assist us in protecting your privacy, please complete the following:

Whom may we speak with other than yourself, regarding your medical care: (if more than one, please list all)

_____

_____

May we leave a message on your voicemail at home? Yes_____ No_____

May we mail medical information to your home? Yes_____ No_____

I have been made aware of the privacy policies of *Hand and Physical Therapy of Wyoming, LP* and have received (or made available to me), a copy of the Notice of Privacy Practices *Hand and Physical Therapy of Wyoming, LP*

Medicare Patient Certification:
I certify that this information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf. Initials: _____

Complaint Policy: All logged complaints will be investigated, acted upon and responded to in writing or by telephone by a manager within five (5) calendar days of receiving a beneficiary's complaint. *Hand and Physical Therapy of Wyoming, LP* shall notify the beneficiary using either oral, telephone, e-mail, fax, or letter format, that is has received the complaint and that it is investigating. *Hand and Physical Therapy of Wyoming, LP* will resolve the complaint within fourteen (14) days. Please do not hesitate to call our compliance officer, Anni Stafford (307-670-9191), Medicare (800-633-4227), CMS State of Wyoming Consumer Hotline (888-393-2789), or BOC at 877-776-2200 to report any concerns or register complaints about *Hand and Physical Therapy of Wyoming, LP*. Initials: _____

Patient History

Please circle the following, if you are presently being treated for any of the following conditions

High Blood Pressure	Yes	No		Fracture	Yes	No
Headaches	Yes	No		Respiratory Conditions	Yes	No
Vertigo	Yes	No		Cancer	Yes	No
Diabetes	Yes	No		Pacemaker	Yes	No
Weight Loss/Weight Gain	Yes	No		Hepatitis	Yes	No
Stroke	Yes	No		Allergies	Yes	No
Pregnancy	Yes	No		Blood Disorder	Yes	No
Arthritis	Yes	No		Autoimmune Disorder	Yes	No
Osteoporosis	Yes	No		Smoke	Yes	No
Joint Replacement	Yes	No		Drink	Yes	No
Others:				Drug Allergies:		

Surgical History (list):_____

_____

Medications Currently Taking: (list):_____

_____

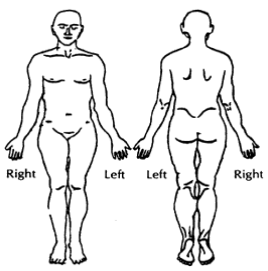
Have you fallen in the last year? (circle one) **Yes or No** If Yes, how many times? _____
If Yes, were you injured? **Yes or No** Do you worry about falling? **Yes or No**
Do you feel unsteady when standing or walking? **Yes or No**

Have you ever received therapy in the past for the condition mentioned above? **Yes or No**
If Yes, date: _____ Describe previous treatment: _____

Please rate your current pain level:

0 1 2 3 4 5 6 7 8 9 10
no pain worst imaginable

Circle where you are experiencing most of your pain.



Patient Name:

PATIENT INTAKE AND CONSENT FORM

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

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

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:
is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE

I hereby release, discharge and acquit:
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:
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** _____