RIDGE PHYSICAL THERAPY & WELLNESS CENTER

Intake Form

Date: _____

Personal Information please print clearly

Name: _____
last first middle initial

Home Address: _____
street city state zip

Home Telephone: (____)_____ Cell Phone: _____

E-Mail Address:_____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M F

Marital Status: S M W D Spouse's name: _____

Nearest Relative (other than spouse): _____

Phone: _____ Relationship: _____

Employment Information

Occupation: _____ Employer: _____

Employer Phone: _____ Ext./Dept. _____

Medical Information

Reason for being seen: _____

Date of injury or onset: _____ Related to work: ____yes ____no
Auto accident: ____yes ____no
Other: ____yes ____no

How injury occur? _____
_____
_____

Who referred you to our clinic? (circle one) MD Friend Advertisement Other

Attorney Information (if applicable)

Name of attorney representing you: _____

Attorney's firm name: _____

Attorney's FULL MAILING address: _____

Attorney's phone: _____

RIDGE PHYSICAL THERAPY & WELLNESS CENTER

Patient's Medical History

Today's Date:_____

Patient name: _____ Sex: M F

Age: _____ Height / weight: _____

Occupation: _____

Leisure activities / hobbies: _____

Referring Physician: _____

Check those that Apply:

_____Recent illness, hospitalizations or surgical procedures
_____Heart Attack, coronary bypass, cardiac surgery
_____Abnormal resting or stress ECG
_____Uneven, irregular, or skipped heart beats (including a racing or fluttering heart)
_____High Cholesterol
_____High Blood Pressure
_____Incontinence (urge, stress, leaking of bladder with coughing or sneezing)
_____List **ALL** past surgeries:_____
_____Diabetes
_____Blood Clots
_____Stroke
_____Pulmonary Disease (asthma, emphysema, bronchitis, other breathing problems)
_____Cancer
_____Pregnant - How many months along? _____
_____Ulcers
_____Orthopedic problems or injuries (arthritis or any other bone, joint, or muscle problems)
_____Emotional / psychological disorders (including stress, anxiety, or sleep disturbances)
_____Physical Inactivity
_____Smoking
_____Medications: _____
_____Allergies: _____

Please List any other health problems:_____

Please indicate any current or past forms of exercise that you have participated in:
_____
_____

What do you hope to achieve in therapy?:_____
_____

RIDGE PHYSICAL THERAPY & WELLNESS CENTER

Insurance Intake Form

Major Medical Billing Information

Major health insurance carrier: _____

SEE COPIES OF CARDS FOR DETAILS

Worker's Compensation Injury Billing Information (if applicable)

Complete information is needed in order to process your claim.

Name of employer: _____

(see intake form for further employer information)

Worker's compensation insurance carrier: _____

Address of carrier: _____
street city state zip

Adjuster's name: _____ Adjuster's phone: _____

Claim #: _____

Auto Accident Injury Billing Information (if applicable)

Complete information is needed in order to process your claim.

Name of no-fault insurance company: _____

Name of the policy holder: _____

Relationship to the policy holder (self, spouse, child, other) _____

Address of insurance company: _____
street city state zip

Ins. company phone #: _____ Adjuster's name: _____

Policy #: _____ Claim #: _____

Release and Assignment (please read and sign below)

I hereby consent and authorize the administration of all procedures. I hereby authorize Ridge Physical Therapy & Wellness Center to release or obtain any information to the insurance company, attorney, or referring physician upon request. I also assign and request payment of medical benefits to Ridge Physical Therapy & Wellness Center.

I also understand that I am financially responsible for any charges not covered by my insurance carrier.

Patient's Signature: _____ Date: _____

Please print your name: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization creates and maintains health records describing my health, history, symptoms, examination and test results, diagnoses, and treatment pertaining to my diagnoses. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication for among the health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer (e.g. insurance carrier) can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and outcomes

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

Our Notice of Privacy Practices is subject to change. If we change our notice, we will provide you with an updated notice.

_____ _____

Patient's Signature Date

_____

Please Print patient's name

_____ _____

Witness Date

Acknowledgment of Receipt of Notice of Privacy Practices was not signed as noted below:

- o Patient Refused to Sign

RIDGE PHYSICAL & WELLNESS CENTER CANCELLATION POLICY

IMPORTANT NOTICE REGARDING MISSED AND CANCELLED APPOINTMENTS

Due to the high number of cancellations and missed appointments (no-shows), Ridge Physical Therapy & Wellness Center is instituting a $25.00 fee for those who do not notify us that they will be unable to attend their scheduled therapy session.

We appreciate at least 24 hours notice if you are unable to attend your scheduled appointment so we can fill your slot with someone who is on our "waiting list". We realize certain things "come up" however, your cooperation in making every effort to give us as much notice as possible if you are not able to attend, is appreciated.

The $25.00 charge will be posted to your account and must be paid before you resume your treatment sessions.

We value your business and hope this doesn't cause you any inconvenience.

Thank you very much.

RIDGE PHYSICAL THERAPY & WELLNESS CENTER

I have read and acknowledge this information.

_____ _____

Signature of Patient Date