VITAL CARE
PHYSICAL THERAPY

Intake Paperwork

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Cell: _____ Home: _____ Work: _____

Email: _____

How would you like to receive your appointment reminders? ( ) Call ( ) Text ( ) Email ( ) None
(Standard text messaging rates may apply)

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

( ) Self Pay (If you selected Self Pay, do not fill out the insurance information below)
( ) Bill Insurance Company

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Release of Information

I authorize Vital Care Physical Therapy to release my medical information to the following:

Name: _____ Phone: _____

Name: _____ Phone: _____

***By signing below, I hereby attest that the above information is accurate to the best of my knowledge.**

Signature: _____ Date: _____

Agreement and Consent

Print Name: _____ Date of Birth: _____

***Please initial the spaces below agreeing that you have read and understand our policies.**

_____CANCELLATION/LATE/NO SHOW FEE: If you wish to cancel or change your appointment, we require 24-hour advance notice. **A fee of $50.00 will be charged to your account if you cancel with less than 24-hour notice, arrive over 15 minutes late OR fail to show up for your scheduled appointment**. Doing so does not allow you to receive the quality of care you need and compromises the care of our other patients. PLEASE BE RESPONSIBLE FOR YOUR SCHEDULE.

_____ ELECTRONIC DEVICES: All cell phones, tablets and/or laptops MUST be shut off or put on silent. We understand emergencies might happen and will allow you to carry your device with you while you are being treated. PLEASE BE COURTEOUS AND SET IT TO SILENT OR TURN OFF YOUR DEVICE.

_____ CHILD SUPERVISION: Children who require supervision are not allowed to attend the appointment while you are being treated. If the child does not require supervision, they may wait patiently in our waiting room. If they cause disruption to our patients or staff members, you may be asked to end your session and attend to the child.

_____TREATMENT AND CARE: I agree and give consent to Vital Care Physical Therapy to create and provide the appropriate and necessary treatment that is in the best interest of my physical condition. I understand that the therapist will go over my treatment plan and discuss the benefits and risks. I also have the right to hold the final decision and judgment in such matters.

_____ FINANCIAL CONSENT: I authorize Vital Care Physical Therapy to submit claims and my personal health information to my insurance company. If I fail to give correct information or enroll in a new plan, it is my responsibility to notify Vital Care Physical Therapy as soon as possible, otherwise I will be responsible for any remaining charges.

_____ ASSIGNMENT OF BENEFITS: We are required to collect copays, deductibles, and co-insurance at the time of visit. Ultimately it is your responsibility to know your insurance benefits. As a courtesy we verify your benefits but always recommend you call your insurance company to have them explain your coverage for physical therapy.

***Your plan benefits that were given to us by your insurance company are as follows**:

Primary Insurance: _____ *Authorization Required ( ) Yes ( ) No

Copay Per Visit: _____ Deductible: _____ Co-Insurance: _____% Cap Limit: _____ Visit Limit: _____

Secondary Insurance: _____

Copay Per Visit: _____ Deductible: _____ Co-Insurance: _____% Cap Limit: _____ Visit Limit: _____

***By signing below, I agree and understand that the benefit information given to me is an <u>ESTIMATE</u> of what I will be responsible for. The final determination will be made once the claims have been fully processed by my insurance company. I understand I will be billed for any remaining balance after my insurance has paid their part.**

Signature: _____ Date: _____

Benefits Explained By: _____ Date: _____

Health History

Print Name: _____ Date of Birth: _____

1. Check mark any health conditions that may apply to your medical history.

( ) High Blood Pressure
( ) Blood Clots Where: _____ When: _____
( ) Vascular Disease: _____
( ) Cellulitis Where: _____ When: _____
( ) Osteoporosis ( ) Osteopenia
( ) Neuropathy
( ) Fibromyalgia
( ) Autoimmune Disease: _____
( ) Heart Disease: _____
( ) Pacemaker/Electronic Devices: _____
( ) Diabetes: ( ) Type 1 ( ) Type 2
( ) Lung Problems: ( ) Asthma ( ) COPD ( ) Emphysema ( ) Valley Fever ( ) Other: _____
( ) Stroke: ( ) CVA ( ) TIA When:_____ Residual Deficits: _____
( ) Neurological Conditions: ( ) Dementia ( ) Alzheimer ( ) Parkinson's ( ) Multiple Sclerosis ( ) Guillain-Barré
( ) Psychological Conditions:_____
( ) Cancer/Tumor: _____ ( ) Chemotherapy ( ) Radiation ( ) Lymph Nodes Removed
( ) Allergies: _____

2. Have you had any of the following diagnostic tests?

( ) X-Ray Date: _____
( ) MRI Date: _____
( ) CT Scan Date: _____
( ) EMG/NCV Date: _____
( ) VNG Date: _____

3. Surgical History: _____
_____
_____

Medication	**Reason**	**Medication**	**Reason**
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

***By signing below, I hereby attest that the above information is accurate to the best of my knowledge.**

Signature: _____ Date: _____

Social Services Screening

Vital Care Physical Therapy is a Comprehensive Outpatient Rehabilitation Facility (CORF). We care about our patients' physical and emotional well-being.

Print Name: _____ Date of Birth: _____

( ) **DECLINE SCREENING** ( ) **ACCEPT SCREENING**

***If you have <u>agreed</u> to participate in the screening, please answer the questions below.**

1. Do you need assistance with daily tasks or activities? ( ) Yes ( ) No

2. Are you currently under the care of a counselor or therapist? ( ) Yes ( ) No

3. Have you experienced any of the following symptoms within the last 2 months?

( ) Loss of sleep
( ) Too much sleep
( ) Change in eating habits
( ) Rapid weight gain
( ) Significant weight loss
( ) Losing interest in activities
( ) Distant from relationships with people/pets
( ) Frequently impaired state
( ) Poor concentration making decisions
( ) Difficulty controlling your feelings
( ) Memories resurfacing from past trauma or experiences

4. Would you like more information on any of the resources listed below?

( ) Transportation
( ) Medical Equipment
( ) Home Repair/House Cleaning
( ) Home/Nursing Care
( ) Meal Preparation
( ) Counseling/Support Groups
( ) Financial Assistance

***By signing below, I acknowledge that I have reviewed this form and have been offered social screening services.**

Signature: _____ Date: _____

OFFICE USE ONLY

Social worker: Were social services indicated? ( ) Yes ( ) NO

Comments:_____

_____

_____

Social Worker Signature: _____ Date: _____

Patient Rights and Responsibilities

Patient Acknowledgement

Print Name: _____ Date of Birth: _____

The Arizona Department of Health Services (ADHS) licenses this office.

We provide a copy of your Patient Rights and Responsibilities, as required by ADHS statutes and rules.

***Please initial one of the two options below.**

____ I have been given a copy of my Patient Rights and Responsibilities to take home.

____ I have read the laminated copy of the Patient Rights and Responsibilities in office and do not want a copy to take home.

***By signing below, I acknowledge that I have been provided with my Patient Rights and Responsibilities and have been offered a copy for my records.**

Signature: _____ Date: _____

Vital Care Physical Therapy
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