Physical Therapy Specialists
7853 E Arapahoe Court
Suite 1400
Centennial, CO 80112
PH: 303-740-2026
Fax: 303-770-5459
www.ptspecialist.com

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Date

Name (Last, first, middle initial) | Parent/Guardian

Street address | City, State, Zip code

Primary phone number | Emergency contact & phone number | Email address

Primary Care Physician | PCP Phone Number | Date of Birth

Sex: **M / F** Previous PT: **Y / N**

Who can we thank for referring you? _____

In an effort to provide the highest quality health care for you, we would like to be able to communicate with your healthcare team. Please provide us with the names and phone numbers of any additional health practitioners involved in your care.

Name of Provider	Type of Care	Phone Number
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_____(Initials) My insurance may reimburse me for services provided by Physical Therapy Specialists. I authorize Physical Therapy Specialists to mail/fax copies of my payments and progress notes, if necessary, to my insurance company for reimbursement.

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Physical Therapy Agreement of Policies

Please note that payment is made by the patient in full at the time of the appointment. **The only exception is Medicare.** Your insurance may offer benefits for out of network providers. As a courtesy, we can call to obtain your benefits for you. Just ask!

Fees are based on time spent with you and the treatments performed during your appointment. The fee ranges are as follows:

Initial Evaluation	$170 – 186
60 Minute Visits	$140 – 152
Follow Up Visits Under 30 Minutes	$70 – 76

To maximize the enjoyment of your visit and in consideration of others, we ask you to carefully read and agree to the following policies:

- Please be ready for your appointment at the scheduled time, arriving early if needed to make a payment, use the restroom, schedule additional appointments, etc. Appointments MUST end at the time scheduled and cannot be extended.
- If you arrive late to your scheduled appointment, you will be billed for the allotted time scheduled.
- Please report any health issues, even minor injuries to your PT before your session begins.
- Cell phones and pagers should be silenced.
- Children must be supervised and cannot interrupt the therapy session. This is to maximize your therapy time. If at all possible, make other arrangements for your child.
- Physical Therapy Specialists is not responsible for lost or stolen property.
- Physical Therapy Specialists has the right to cancel an appointment the day of service due to family emergency, weather or illness. The appointment will be rescheduled for the next available time slot.

I have fully read, understood, and agree to follow the above policies.

Print Name	Signed	Date

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Conditions and Consent for Physical Therapy

Cooperation with Treatment
I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. Late arrivals will be billed for the time scheduled. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of occupational therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Informed Consent for Treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Release of Medical Records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Financial and Insurance Responsibilities
I agree to pay for my treatments at time of service, by cash, check, or credit card unless other mutually agreed upon arrangements have been made. I understand it's my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand that I will provided with a paid receipt for services.

I understand that I am a patient of Physical Therapy Specialists, P.C., at 7853 E. Arapahoe Court., Suite 1400, Centennial, CO, 80112. I agree to hold Physical Therapy Specialists harmless for any and all actions, causes of action claims, demands, damages, costs, loss of services, expenses, compensation, and all consequential damages, and particularly on account of all injuries, both to my person and to my property, which have resulted or in the future may develop, or arise out of services and/or treatment. My care is the exclusive responsibility of Physical Therapy Specialists, P.C.

I have read the above information and I consent to physical therapy evaluation and treatment.

_____ _____

Print Name Date

_____ _____

Signed Witness signature

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Cancellation and Missed Appointment Policy

Our goal is to provide quality, individualized physical therapy in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need therapy. Following, is our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of treatment.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients on our waiting list, please be courteous and call the office promptly if you are unable to attend a scheduled appointment. Your appointment time will be reallocated to another patient in need of treatment. Appointments are in high demand and your early cancellation will give another patient the opportunity to have access to that appointment time. **If it is necessary to cancel your appointment, we require a call or text at least 48 hours in advance. Cancellations for Mondays must be received by the previous Friday by 5:00 pm. Two consecutive late cancellations or no-shows may warrant discharge from physical therapy.**

How to Cancel an Appointment

To cancel appointments please call or text **303-740-2026**. If you do not reach the office staff, you may leave a detailed message on voicemail. It is considered a late cancellation when a patient cancels their scheduled appointment without 48 hours advance notice. ***If we do not receive 48 hours' notice, you will be charged a $50.00 fee the first time and the cost of your last appointment the second time***.

No Show Policy

A"no-show" is someone who misses a scheduled appointment without notice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as "no- show". ***For a "no -show" appointment, you will be charged a $50.00 fee the first time and the cost of your last appointment the second time***. Two consecutive late cancellations or no-shows may warrant discharge from physical therapy.

Late Arrivals

In the event you are running late for your appointment, it is appreciated to call ahead to notify us of your expected late arrival. Please note that in order for us to accommodate other patients we will not be able to extend your appointment time and you will be charged the full amount for your visit.

Please take advantage of our Reminder Services. Appointment reminders can be delivered via phone call, text or email. Let us know the method that works best for you.

I have read the new policy above and agree to the terms.

_____	_____	_____
Signature	*Print Name*	*Date*

Please note: Exceptions will be made on a case by case basis.

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Consent to Use and Disclosure of Health Information

Physical Therapy Specialists

By signing this form, you are granting consent to Physical Therapy Specialists to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revise notice by contacting us at 303-740-2026. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I have received a copy of the "Notice of Health Information Privacy Practices."

_____ _____

Signed Date

Communication Consent

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means; such as sending correspondence to the individual's cell phone number instead of an individual's home phone number.

I wish to be contacted in the following manner (Check all that apply):

- ☐ Primary Phone # _____
  - ☐ OK to leave voicemail message with detailed information
  - ☐ OK to leave message with a family member
  - ☐ Leave message with call back number only
- ☐ Secondary Phone # _____
  - ☐ OK to leave voicemail message with detailed information
  - ☐ OK to leave message with a family member
  - ☐ Leave message with call back number only

Written Communication:

- ☐ OK to **email** at this address: _____
- ☐ OK to mail to my **home address**

My PREFERRED method of contact for appointment reminders is: **TEXT** **VOICE MESSAGE** **EMAIL** (circle one)

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How to Determine Your Insurance Benefits for Physical Therapy

KEEP THIS WORKSHEET FOR YOUR RECORDS

1. Call the 1-800 # for customer service on your insurance card. Select the option that will allow you to speak with a customer service provider, not an automated system.

2. Ask the customer service provider to quote your physical therapy benefits in general. These are frequently termed rehab benefits and can include occupational therapy, speech therapy, and sometimes massage therapy.

3. Make sure the customer service provider understands you are seeing a non-preferred provider/out of network provider who your doctor referred you to.

What YOU need to know:

- Do you have an **OUT OF NETWORK** deductible? _____ If so, how much is it? _____
- How much of the deductible has already met? _____
- What percentage of reimbursement do you have after the deductible is met? (60%, 80%, 90%, are all common) _____
- Does your policy require a written prescription from your primary care physician? _____
- Does your policy require pre-authorization or a referral on file for outpatient physical therapy services? _____
- How many physical therapy visits are allowed per year? _____
- Is the plan based on a calendar year? _____ If not, what are the plan dates? _____

What this information means:

- A deductible must be satisfied before the insurance company will pay for therapy treatment. We will help you submit all payments to help reach the deductible amount.

- If you have an office visit co-pay the insurance company will subtract that amount from the percentage they will pay. This will affect the amount of reimbursement you will receive.

- The reimbursement percentage will be based on your insurance company's established "reasonable and customary/fair price" for the service codes rendered. This price will not necessarily match the charges billed. Some may be less than you have paid.

- If your policy requires a prescription from your PCP, you must obtain one to send in with the claim. This is usually not difficult to obtain since your PCP sent you to a specialist for help with your condition. If the prescription from a MD or specialist is all you need, make sure to have a copy to include with your claim. Each time you receive an updated prescription you'll need to include it with the claim.

- If your policy requires pre-authorization or a referral on file and the insurance company doesn't have one listed yet, you'll need to call the referral coordinator at your PCP's office. Ask them to file a referral for your physical therapy treatment that is dated to cover your first physical therapy visit. Be aware that referrals and pre-authorizations have an expiration date and some set a visit limit. If you are approaching the expiration date or visit limit you'll need the referral coordinator at your doctor's office to submit a request for more treatment.

This worksheet was created to assist you in obtaining reimbursement for physical therapy services and is not a guarantee of reimbursement to you.

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Patient History

Name _____ **Age** _____ **Date** _____

1. Describe the current problem that brought you here: _____

_____

2. When did your problem first begin? _____ **months ago or** _____ **years ago.**

3. Was your first episode of the problem related to a specific incident? **Yes/No**
Please describe and specify date: _____

_____

4. Since that time is it: **staying the same** **getting worse** **getting better**
Why or how? _____

5. Rate the severity of this problem from 0 -10 with 10 being the worst: **1 2 3 4 5 6 7 8 9 10**

6. If pain is present, rate pain on a 0-10 scale 10 being the worst: **1 2 3 4 5 6 7 8 9 10**
Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

_____

7. Date of Last Physical Exam _____ Tests performed _____

8. Describe previous treatment/exercises: _____

_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities): _____
Diet /Fluid intake: _____
Physical activity: _____
Work, specify _____
Other _____

10. Activities/events that cause or aggravate your symptoms - check/circle all that apply:

___Sitting longer than ____minutes
___Walking longer than ____minutes
___Standing longer than ____minutes
___Changing positions (i.e. sit to stand)
___Light activity (light housework)
___Vigorous activity/exercise (run/weight lift/jump)
___Sexual activity
___Other, please list _____

___With cough/sneeze/straining
___With laughing/yelling
___With lifting/bending
___With cold weather
___With triggers (running water/key in door)
___With nervousness/anxiety
___No activity affects the problem

11. What relieves your symptoms? _____

_____

12. What are your treatment goals? _____

Pg 2 Patient History **Name**_____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Other /describe_____
Y/N Malaise (Unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling

General Health**: Excellent Good Average Fair Poor**

Occupation _____
Hours/week_____ On disability or leave? **Y/N** **Activity Restrictions?** _____

Activity/Exercise: **None** **1-2 days/week** **3-4 days/week** **5+ days/week**
Describe _____

Mental Health: Current psych therapy? **Y/N**
Current level of stress: **High Med Low**

Have you ever had any of the following conditions or diagnoses? Circle all that apply /describe:

Cancer
Heart problems
High Blood Pressure
Ankle swelling
Anemia
Low back pain
Sacroiliac/Tailbone pain
Alcoholism/Drug problem
Childhood bladder problems
Depression
Anorexia/bulimia
Smoking history
Vision/eye problems
Hearing loss/problems
Stroke
Epilepsy/seizures
Multiple sclerosis
Head Injury
Osteoporosis
Chronic Fatigue Syndrome
Fibromyalgia
Arthritic conditions
Stress fracture
Rheumatoid Arthritis
Joint Replacement
Bone Fracture
Sports Injuries
TMJ/ neck pain
Headaches
Emphysema/chronic bronchitis
Asthma
Allergies-list below
Latex sensitivity
Hypothyroid/ Hyperthyroid
Irritable Bowel Syndrome
Diabetes
Kidney disease
HIV/AIDS
Hepatitis
Sexually transmitted disease
Physical abuse
Unwanted sexual encounter
Pelvic pain
Raynaud's (cold hands and feet)

Other/Describe_____

Surgical /Procedure History:

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe_____

Ob/Gyn History *(females only)*

Y/N Childbirth vaginal deliveries #____
Y/N Episiotomy #____
Y/N C-Section #___
Y/N Difficult childbirth #____
Y/N Prolapse or organ falling out
Y/N Other /describe_____
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? ___
Y/N Painful vaginal penetration
Y/N Pelvic pain

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Other /describe_____

Y/N Erectile dysfunction
Y/N Painful ejaculation

Medications-(pills, shot, patch)	Start Date	Reason for taking

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems:

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe _____

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

1. Frequency of urination:
   While awake: ____ **times per day** During sleep hours: ____**times per night**

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   minutes **hours** **not at all**

3. The usual amount of urine passed is: **small** **medium** **large**

4. Frequency of bowel movements:
   ___times per day, ___times per week, or _____.

5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? **minutes** **hours** **not at all**

6. If constipation is present describe management techniques: _____

7. Average fluid intake (one glass is 8 oz or one cup) _____**glasses per day**
   Of this total how many glasses are caffeinated?_____**glasses per day**

8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
___None present
___Times per month (specify if related to activity or your period)
___With standing for ___minutes or ___hours
___With exertion or straining
___Other

Skip the following questions if no leakage/incontinence occurs:

9a. Bladder leakage - number of episodes
___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___No leakage
___Times per day
___Times per week
___Times per month
___Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please choose only one)
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

12. Physical Therapy Expectations:

We would like to determine your expectations for your physical therapy outcomes. In order to do so, please answer based on what you think will occur with your treatment versus what you would like to occur.

At the end of physical therapy treatment, what do you expect will be the pain associated with your condition?

Worsen **Stay the same** **Improve**

At the end of your physical therapy treatment, what do you expect will be your ability to perform a task you are currently unable to do (such as sit, walk, stand, clean house, play golf, etc.)?

Worsen **Stay the same** **Improve**