Personal Insurance Intake Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_/\_\_\_/\_\_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_ / \_\_\_\_\_\_\_\_

Sex: M or F Cell phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Home phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this injury due to a motor vehicle accident or worker’s compensation case: YES / NO

If under 18 years, name/phone number of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency contact number: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Primary Care Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_

Primary Care Physician Practice Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician #: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us: I’m a regular! Referred by a friend My doctor sent me

 Website mail flyer Other: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle Yes or No for each condition:**

Yes No Do you or have you suffered from depression?

 Yes No Do you or have you had anxiety in the past?

Yes No Do you have high blood pressure?

Yes No Do you have heart disease?

Yes No Do you experience shortness of breath?

Yes No Do you experience angina (chest pain)?

Yes No Do you have lung disease?

Yes No Do you experience heartburn or stomach pain?

Yes No Have you experienced recent weight loss?

Yes No Do you have a thyroid condition?

Yes No Do you have diabetes?

Yes No Do you have low blood sugar?

Yes No Do you have a history of cancer?

Yes No Have you experienced an increase in frequency of intensity of headaches?

Yes No Do you have osteoporosis?

Yes No Do you have unusual joint pain and/or swelling?

Yes No Do you have a history of fractures?

Yes No Do you have impaired vision?

Yes No Do you have impaired hearing?

Yes No Are you now or do you believe you may be pregnant?

Injury Information:

Describe the problem you are seeing the physical therapist for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had other treatments for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark where you have symptoms on the picture below**. Also mark any areas of numbness/tingling or other unusual sensations:

****

**Please circle/describe your symptoms:**

R

R

Constant (24 hours/day)

Intermittent (comes and goes)

Knife-like/ Sharp

Burning

Pins and Needles

Dull

L L

Numbness

Aching

Throbbing

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your condition due to a motor vehicle accident? Yes No** If yes, date of accident: \_\_\_/\_\_\_/\_\_\_\_\_\_

**Did you injure yourself at work? Yes No** If yes, date of accident: \_\_\_/\_\_\_/\_\_\_\_\_\_

**Have you had any falls in the past 12 months?** **Yes No** If yes, date of fall: \_\_\_/\_\_\_/\_\_\_\_\_\_

**Please list all current Medications and dosages (or attach a list):**

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage: \_\_\_\_\_\_\_\_\_\_\_ reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage: \_\_\_\_\_\_\_\_\_\_\_ reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage: \_\_\_\_\_\_\_\_\_\_\_ reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement of Office Policies

The following are Redpoint Physical Therapy’s polices for cancellations, consent, and release of information. Please read carefully and ask if you have any questions.



**Cancellation policy**: Redpoint Physical Therapy understands that there are times when you may need to cancel or reschedule your appointment. Please do your best to provide 24 hours’ notice in order to avoid a cancellation fee of $25.00. It is your job as a patient to attend appointments in order to get better. If you miss more than 3 appointments without notice, you may be discharged from care and fees may be applied.

**Consent for Treatment:** I, the undersigned, give Redpoint Physical Therapy my permission to perform a full evaluation and treatments as necessary.

**Assignment of payment:** I hereby authorize my insurance company and/or my attorney to pay direct to Redpoint Physical Therapy, Inc any monies due on my account for professional services rendered.

**Payments for Services:** It is further understood that I, the undersigned, will be responsible for the full amount of the charges should my treatment sessions not be covered by insurance. I also understand that I am responsible for whatever fees my insurance company does not pay on my claim (e.g. co-payments or deductibles).

**Authorization to Release Information:** I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

**Patient Request for Records:** I authorize the release of all pertinent medical, hospital, or surgical records to Redpoint Physical Therapy.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_\_

Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_\_

Name (Please Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Redpoint Physical Therapy Privacy Notice Acknowledgement

In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are required to supply you with a copy of our privacy practices. You have the right to review that notice before you sign this acknowledgment form. We encourage you to read this document carefully as it details the limitations of use and disclosure of your personal and/or health information and your rights as a patient.

As always, we are happy to address any questions you may have regarding the use of this information.

*I acknowledge that I understand the contents of the Redpoint Physical Therapy Notice of Privacy Practices for Protected Health Information.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­\_\_\_ / \_\_\_ / \_\_\_\_\_\_\_\_



Patient Authorization, Billing and Payment Agreement

It is the patients (your) responsibility to know whether their insurance requires a prior authorization for treatment at our Physical Therapy Clinic. Please contact your primary health insurance and/or your Primary Care Physician to determine if this authorization is needed prior to receiving services from our clinic.

If you do not obtain authorization for the services provided, Redpoint Physical Therapy can hold you responsible for any and all claims and bills that are denied or not covered by your insurance. This is also the case if there is a change in your insurance and you do not make us aware of such changes. You are also required to make us aware prior to treatment if your treatment is the result of a work or auto injury or any other second or third-party claim where your insurance would not be the primary payer.

By signing this agreement, you are stating that you have read this agreement and understand your responsibility noted above. That you can be held liable for any amounts owed for services provided by Redpoint Physical Therapy not covered by insurance or any other party.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature Date