Stay Mobile Physical Therapy
PT That Fits Your Life

Stay Mobile Physical Therapy LLC
Solon, OH
Phone: 440-462-9370
Fax: 330-915-3876
www.staymobilept.com

Patient Intake Form

Demographic Information:

_____ _____

Full Name (as it appears on your insurance card) Preferred Name/Nickname

_____ _____

Street Address City, State Zip Code Phone #

_____

Email address: we will use for sending home exercise program and clinic info

_____ _____ _____

Date of Birth Age Gender

Appointment Confirmation Preferred Method (circle one):

Phone Call Text Message Email No reminders please

Occupation: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

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Insurance Information:

_____ _____

Insurance Co. Name Responsible Party

Policy#:_____

Group #:_____

If responsible party is other than self: _____

Primary Subscribers Name and Date of Birth Responsible Party's Phone #

Secondary Insurance Carrier:_____

Subscribers Name and Date of Birth Responsible Party:_____

Policy#:_____

Group #:_____

Referring Physician:

_____ _____

Name of Referring Physician Physician Phone #

Date of next visit with referring physician Primary Care Physician: _____

Primary Care Phone #: _____

_____ _____

Patient or Guardian Signature Date

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Patient Questionnaire/ Medical History

Name: _____ Date of Birth: _____

What is your Chief Complaint?

_____

_____

Rate your chief complaint in order of severity from worst (10) to least (0)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____ Loss of function_____

Where is your problem? _____.

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing___Shooting ___Aching

___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

When and how did this problem begin?_____

_____

What makes your symptoms/ pain worse?_____

_____

What makes your symptoms/ pain lessen?_____

_____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain:_____

Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent_____

Are your symptoms: _____Improving _____Worse _____Stable_____

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Has this problem affected your daily life or routine? Briefly describe in what ways._____

_____

_____

Have you had past similar episodes of this current problem? _____

If yes, were you treated with;

(circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other, Did they help to alleviate your symptoms?_____

_____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?_____

_____

Please answering the following questions:	Yes	No
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies? If yes please list_____		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive device? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) History of cancer?		
20) Do you have a Pacemaker?		

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Any other illness, past injuries I should be aware of?_____

Past surgeries___yes, ___no, give brief details:_____

List the medications you are currently taking (over the counter/prescription):_____

_____

_____

Social History

Are you presently working? _____Yes, _____No, since:_____

_____

Physical/Emotional demands of present occupation? (High, moderate, minimal)_____

_____

Overall activity level: _____Sedentary, _____Light, _____Moderate, _____Heavy, _____Very heavy.

Sports and Exercise (Type, Frequency, Duration) _____

_____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No.

Family medical History:

Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?_____

_____

_____

Please list 3 goals of Physical Therapy and time frames:

1)_____

2)_____

3)_____

Patient Signature (Parent/Guardian if necessary):_____ Date:_____

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CONSENT FOR CARE AND TREATMENT:

I, hereby agree and give my consent for Stay Mobile Physical Therapy LLC to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (initial)

FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize Stay Mobile Physical Therapy LLC to treat the minor patient named in the attached forms while I am not present. _____ (parent/guardian initial)

By signing below, I agree that all of the above information is correct, and that I authorize Stay Mobile Physical Therapy LLC to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment.

Patient Signature (Parent/Guardian if necessary):_____ Date:_____

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Payment and Insurance Policy

FINANCIAL POLICY: It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, coinsurance and deductibles at the time of each visit.

PATIENT'S RESPONSIBILTY: It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status. (Initial):_____

It is the patient's responsibility to:

- Understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurances, and/or deductibles at time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier

INSURANCE PATIENTS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Stay Mobile Physical Therapy LLC to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Stay Mobile Physical Therapy LLC. __ _ ___ (Initial)

MEDICARE PATIENTS – (please provide card)

Have you had any PT this year provided in your home or in another outpatient clinic? Yes No

# of visits_____

Do you currently have Medicare home services? Yes No

Medicare ID:_____

SELF PAY PATIENTS:

For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. __ ___ (Initial)

_____ _____

Patient or Guardian Signature Date

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HIPPA NOTIFICATION

Notice of Privacy Practices for Protected Health Information Health Insurance Portability & Accountability Act of 1996 (HIPAA) Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Stay Mobile Physical Therapy LLC is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either electronically or on paper.

I have read and fully understand Stay Mobile Physical Therapy LLC's Notice of Information Practices. I understand that Stay Mobile Physical Therapy LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment.

Please Select One:

o Waiver (Receive HIPAA Electronically) I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice. I am aware that this Notice is available to me online at Stay Mobile Physical Therapy LLC's website, www.staymobilept.com, and I choose to receive such Notice electronically. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____Signature:_____ Date Signed: _____

OR

o Acknowledgement (Receive HIPAA Paper Copy) I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name:_____ Signature:_____ Date Signed:_____