Patient Intake Form

Please answer the following questions prior to your first visit.

* Required

1. Email address *

2. Patient's Name *

3. Phone Number

4. Address

5. City

6. State

7. Zip Code

____

8. Date of Birth *

____

Example: January 7, 2019

9. Gender

Mark only one oval.

- ( ) Female
- ( ) Male
- ( ) Other: _______________

10. Employment Status

Mark only one oval.

- ( ) Employed *Skip to question 11*
- ( ) Retired *Skip to question 18*
- ( ) Student *Skip to question 18*

Employment Information

11. Employer

____

12. Occupation

____

13. Phone Number

____

14. Address

____
____
____
____
____

15. City

____

16. State

____

17. Zip Code

____

Injury/Condition Information

18. Reason for Therapy

Mark only one oval.

- Work Related
- Auto Related
- Home Related
- Other: ______________________

19. Date of Injury

____

Example: January 7, 2019

20. Date of Surgery

____

Example: January 7, 2019

21. Diagnosis

____

Referral Information

22. Referring Doctor

____

23. Doctor's Phone Number

____

24. Doctor's Address

25. City

26. State

27. Zip Code

Emergency Information

28. Emergency Contact Name

29. Relation

30. Phone Number

Primary Insurance Information

31. Primary Insurance Name

32. Medicare Number or Policy Number *

33. Group Number
Not applicable if you have Medicare

34. Insurance Phone Number

35. Insurance Address

36. City

37. State

38. Zip Code

39. Do you have a Secondary Insurance Company? *

Mark only one oval.

- Yes
- No *Skip to question 48*

Secondary Insurance Information

40. Secondary Insurance Name

41. Medicare or Policy Number *

42. Group Number

Not applicable if you have Medicare

43. Insurance Phone Number

44. Insurance Address

45. City

46. State

47. Zip Code

Insurance Terms

Your insurance company will be billed for the physical therapy services rendered. This does not release you from ultimate responsibility for payment of my services. Any fees not covered by your insurance company will be charged to you.

You cannot concurrently be receiving services from On the Move Physical Therapy and a Home Health Agency. Medicare will not pay for both. If this should occur, you will be held responsible for the services not covered by Medicare.

Copayments and other incurred fees will be billed to you after each treatment session.

If you are unable to keep an appointment, please call to reschedule. Failure to cancel your appointment within 24 hours of the scheduled time will result in a $50.00 fee. A cancelled or missed appointment with no prior phone call will result in a $100 fee billed directly to you.

48. I have read, understand, and agree to the above stated financial responsibilities. I hereby authorize the release of medical information necessary to process claims, the payment of medical benefits to On The Move Physical Therapy, and consent to receiving physical therapy treatments. *

Check all that apply.

☐ Yes

49. Electronic Signature of Patient or Guardian *

____

HIPAA Release Terms

1. The following specific person or class of persons or facility is authorized to make the request to use or disclose Protected Health Information about me; any and all physicians, hospitals, clinics, medical care providers, insurance entities and government entities. 2. The following person or class of persons may receive disclosure of Protected Health Information about me: any representative of On The Move Physical Therapy, 205 N Hermosa Ave, Sierra Madre, CA 91024.3. The specific information that should be disclosed is: any and all medical records, medical history forms, pain diagrams, narrative reports, treatment notes, transcript of radiology reports, psychiatric or psychological records, or other documentation including medical bills, statements for medical services rendered, pertaining to the person who has signed this authorization. 4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. 5. I may revoke this authorization by notifying all health care providers in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me whether or not I sign the authorization. 6. This authorization expires in two (2) years, OR upon occurrence of the following event that relates to me or to the purpose of the intended use of disclosure of information about me. 7. A copy or a fax of this authorization will be valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical records.

50. Electronic Signature of Patient or Guardian *

____

51. How did you find out about On The Move PT?

Mark only one oval.

- ◯ Internet Search
- ◯ Family/Friend
- ◯ Doctor
- ◯ Other: ____________________

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