NEW PATIENT INTAKE FORM

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE/ZIP CODE: _____

PHONE: _____ CELL: _____ WK: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INS: _____ PHONE: _____

ADDRESS: _____

INSURANCE ID: _____ GROUP: _____

PRIMARY INSURED: _____ DOB: _____

PHONE: _____ RELATIONSHIP: _____

SECONDARY INS: _____ PHONE: _____

ADDRESS: _____

INSURANCE ID: _____ GROUP: _____

SECONDARY INSURED: _____ DOB: _____

PHONE: _____ RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN: _____

PHONE: _____ FAX: _____

REFERRING PHYSICIAN: _____

PHONE: _____ FAX: _____

INJURY: _____ DATE OF INJURY: _____

IS INJURY WORK RELATED: ☐ YES ☐ NO

IS INJURY RELATED TO AUTO ACCIDENT: ☐ YES ☐ NO

Agility
Physical Therapy and Sports Medicine

Agility Physical Therapy
And Sports Medicine
7375 E. Orchard Rd.
Suite 200
Greenwood Village, CO 80111

p 303.773.0771
P303.773.0773

www.agilityphysio.com

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Physical Therapy
and
Sports Medicine

7375 E. Orchard Rd Suite 200|Greenwood Village, CO 80111
(303)773-0771

Physical Therapy Consent

1. I _____ give permission for APTASM to provide evaluation, diagnoses and treatment for my current injuries/ailments.
2. _____ I understand that I play a pivotal roll in my healing process and I must do the exercises and home program that are provided by my care provider. I Must also attend all scheduled appointments or incur a **$75 fee if 24hr notice is not given and charged to card on file**
3. _____I understand that I am responsible for my portion of deductible, co-pay or co-insurance that my health insurance company tells my provider I am responsible for and I will **PAY IN A TIMELY MANNER** or be subject to interest charges and Collection fees. I also understand that in the event **my Insurance takes longer than 90 days to pay I will be billed** the best of Knowledge in-Network Rate for APTASM participating rate of Insurance plans. I Hereby agree to pay all collection fees and Attorney fees in the event that my account is assigned to collections to enforce payment of this debt.
4. _____ I understand that if I have a check returned I will be responsible for any bank charges and a$40 fee for service and no longer allowed to pay by check.
5. _____ I understand that I have the right to refuse billing my insurance company and pay a cash pay rate of **$85 for 30 minutes/Follow Ups; $140 for 60 minutes/Exams**, Or I may pay **$140 for the initial** session and an Up Front total of **$480 for 6 sessions or $750 for 10 sessions**
6. _____ I understand I have the right to refuse and specific type of treatment and agree to communicate with my care provider those desires.
7. _____ I give APTASM permission to contact any of my other care providers regarding my injuries and obtain prior medical records so that the best care possible may be provided for me by my PT.

Permission to Leave Messages

I give permission for a representative of Agility Physical Therapy and Sports Medicine to leave a message in any of the following locations:

_____ Home: _____

_____ Cell: _____

_____ Email: _____

Patient Name: _____

Patient Signature: _____Date: _____

Agility
Physical Therapy
and
Sports Medicine

Financial Policy

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card (2% fee for each transaction). Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company including fees for needling at $3 per session and cold laser treatment at $18/session. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!) We also require Insurance card at first session or you will be billed the cash rate.

Agility Physical Therapy and Sports Medicine **Will keep a card on File in protected space through encrypted data transfer for each patient. This credit card on file will be charged for all no-shows and balances over 90days.**

2. INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.** If your insurance company does not pay the practice within a reasonable period of time (90days), you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, **our staff cannot guarantee your eligibility and coverage.** Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement form our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy. Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to you at the time if service. We take liens on a case by case basis and charge a $25 fee for each D.O.S. at time of service.

3. LATE CHARGES of 22% annually will be applied to all patient balances 60 days old or greater.

4. RETURNED CHECKS will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in ARAPAHOE County.

5. ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance Payments, which are applied to the corresponding dates of service.

6. FORMS FEES: Completing insurance forms, copying medical records, etc. requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records when requested by the patient are as follows: $14.50 for the first ten (10) pages and $0.50 per page 11-40 and $0.33 per 41+. We have 15 days to make said copies and these 15 days will commence after payment for copying has been received and

after patient has signed this form authorizing records' release. 3rd parties requesting copies have a different fee and you can find that at Health Facilitates and Emergency Medical Services Division website.

7. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $75 missed appointment fee. **10-15 Minutes late counts as a No-Show** unless the appointment time after you is open and or another provider can care for you within the day or week (2 sessions per week are kept if 2 were scheduled.)

8. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Agility Physical Therapy and Sports Medicine for charges not covered by My insurance company for ANY reason.

9. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to Agility Physical Therapy and Sports Medicine sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to me or my dependent in said clinic. I authorize Agility Physical Therapy and Sports Medicine to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Agility Physical Therapy and Sports Medicine. I authorize Agility Physical Therapy and Sports Medicine to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

10. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

11. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the first day of service **accepts responsibility for payment**. This office **does not promise to send bills or records to the other parent/guardian for issues of payment or communication**. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print the name of the patient and their Date of Birth

_____

address for communication:

_____ _____ _____

city State Zip

Patient Health Questionnaire - PHQ

ACH Group, Inc - From PHq-202

ACH Group Use Only rev 9/11/2002

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ☐ Constantly (76 - 100% of the day)
- ☐ Frequently (51 - 75% of the day)
- ☐ Occasionally (26 - 50% of the day)
- ☐ Intermittently (0 - 25% of the day)

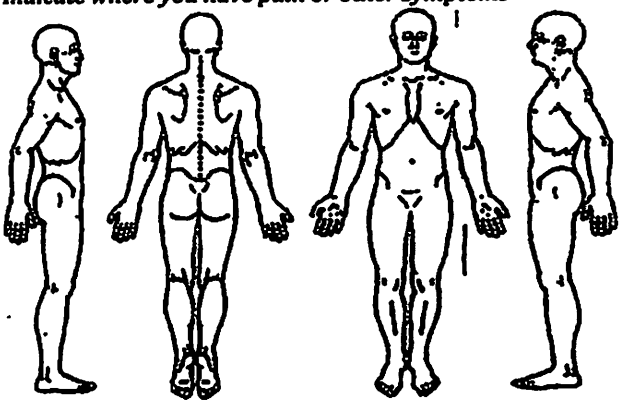
3. What describes the nature of your symptoms

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

Indicate where you have pain or other symptoms



5. During the past 4 weeks:

None *Unbearable*

a. Indicate the average intensity of your symptoms ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐1

b. How much has pain interfered with your normal work (including both work outside the home and housework)

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? *(like visiting with friends, relatives, etc)*

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time

7. In general would you say your overall health right now is...

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

8. Who have you seen for your symptoms?

☐No One ☐Medical Doctor ☐Other
☐Chiropractor ☐Physical Therapist

b. What treament did you receive and when?

a. What tests have you had for your symptoms and when were they performed?

☐Xrays *date:* ☐CT Scan *date:*
☐MRI *date:* ☐Other *date:*

9. Have you had similar symptoms in the past? ☐Yes ☐No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐Xrays *date:* ☐CT Scan *date:*
☐MRI *date:* ☐Other *date:*

10. What is your occupation

☐Professional/Executive ☐Laborer ☐Retired
☐FT Student ☐Homemaker ☐Other
☐Tradesperson ☐White Collar/Secretarial

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐Full-time ☐Self-employed ☐Off Work
☐Part-time ☐Unemployed ☐Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACH Group, Inc - From PHq-202

ACH Group Use Only rev 9/11/2002

Patient Name ***Date***

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? **Height** ____ ____ ____ **Weight** ____ ____ ____ lbs

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past, if you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present
☐	☐ Headaches		☐	☐ High Blood Pressure		☐	☐ Diabetes
☐	☐ Neck Pain		☐	☐ Heart Attack		☐	☐ Excessive Thirst
☐	☐ Upper Back Pain		☐	☐ Chest Pains		☐	☐ Frequent Urination
☐	☐ Mid Back Pain		☐	☐ Stroke			
☐	☐ Low Back Pain		☐	☐ Angina		☐	☐ Smoking/Use Tobacco Products
						☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain		☐	☐ Kidney Stones			
☐	☐ Elbow/Upper Arm Pain		☐	☐ Kidney Disorders		☐	☐ Allergies
☐	☐ Wrist Pain		☐	☐ Bladder Infection		☐	☐ Depression
☐	☐ Hand Pain		☐	☐ Painful Urination		☐	☐ Systematic Lupus
			☐	☐ Loss of Bladder Control		☐	☐ Epilepsy
☐	☐ Hip/Upper Leg Pain		☐	☐ Prostate Problems		☐	☐ Dermatitis/Eczema/Rash
☐	☐ Knee/Lower Leg Pain					☐	☐ HIV/AIDS
☐	☐ Ankle/Foot Pain		☐	☐ Abnormal Weight Gain			
			☐	☐ Loss of Appetite		*Females Only*	
☐	☐ Jaw Pain		☐	☐ Abdominal Pain		☐	☐ Birth Control Pills
			☐	☐ Ulcer		☐	☐ Hormonal Replacement
☐	☐ Joint Swelling/Stiffness		☐	☐ Hepatitis		☐	☐ Pregnancy
☐	☐ Arthritis		☐	☐ Liver/Gall Bladder Disorder		☐	☐
☐	☐ Rheumatoid Arthritis						
			☐	☐ Cancer		*Other Health Problems*	
☐	☐ General Fatigue		☐	☐ Tumor		☐	☐
☐	☐ Muscular Incoordination					☐	☐
☐	☐ Visual Disturbances		☐	☐ Asthma		☐	☐
☐	☐ Dizziness		☐	☐ Chronic Sinusitis		☐	☐

Indicate if an Immediate family member has had any of the following:

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized

_____ _____ _____

_____ _____ _____

Patient Signature ***Date***

Doctor's Additional Comments

_____

_____

_____

Doctor's Signature ***Date***

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____