

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



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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: _____



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 your 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 your 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 of 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 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

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

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 treatment 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: _____

Yes

No

9. Have you had similar symptoms in the past?

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

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

Professional/Executive

Laborer

Retired

FT Student

Homemaker

Other

Tradesperson

White Collar/Secretarial

Full-time

Self-employed

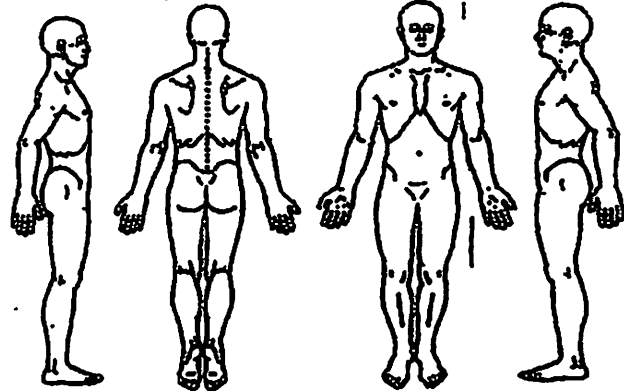
Off Work

Part-time

Unemployed

Other

Indicate where you have pain or other symptoms



Patient Signature _____

Date _____

QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (circle number)

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

QuickDASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n} \right] - 1 \right) \times 25$, where n is equal to the number of completed responses.

A QuickDASH score may **not** be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is: _____

I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: _____

I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.

An optional module score may not be calculated if there are any missing items.