Patient Intake Form

Patient Information:

Last name: ______________________________ First Name: ______________________________ Sex: ___________________

Date of Birth: ____________________________

Address: ____City: ______________________State: ___________

Zip Code: _______________ Preferred Contact Phone #: (_______) ____________________Cell/Home/Work (circle one)

Email: ____

Physician's Name: ____ Diagnosis: _______________________________________

Injury: Work or Auto related? Yes No (circle one) If yes, which: _______________________________________

Emergency Contact: _______________________________________ Phone #: (________) _____________________________

Insurance Information:
Insurance Co. Name: ____ Policy #: __________________________________

Patient Responsibility: ____

We will take a copy of your payment method and place in your file

I hereby accept responsibility for the cost of this examination or treatment in the event that the insurance company denies this claim. **We will make every effort to verify your insurance coverage for treatment; however, it is your responsibility to understand the terms of your insurance coverage. (co-pay, deductible)**

Patient Signature: ____

Patient History

What is your Chief Complaint? ____

____

Has this problem affected your daily life or routine? Briefly describe in what ways: ________________________________

____

When and how did this problem begin: ____

____

Rate your pain, at this moment, on a visual scale (0-10) 0 = no pain, 10 = excruciating: __________
Worst it has been: __________ Best it has been: __________

Have you undergone any special tests for this condition? (X-rays, MRIs, ETC) If yes, do you know the results:

____

Medications (Please write in or provide a list): ____

____

Any Allergies: ____

Please answer 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 any recent change in your weight?		
6) Do you have any bruising or bleeding disorders?		
7) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
8) Do you have osteoporosis? Date or your last bone scan:		
9): Have you used steroids for any prolonged period of time?		
10) Have you noticed any shortness of breath or decrease in exercise tolerance		
11) Do you have high blood pressure?		
12) Do you have any cardiac problems?		
13) Do you have a pacemaker?		
14) Do you have diabetes?		
15) Have you ever had cancer of any sort?		
16) Are you pregnant (women only)?		

Any other illness, past injuries, surgeries, or medical history I should be aware of?

____

Goals you have for Physical Therapy:

____

Who can we thank for this referral?

____

I give Delmarva PT Services, LLC permission to use my picture, when appropriate, to use on webpage, Facebook, Instagram. Delmarva PT Services, LLC will again ask for verbal approval at time of request.

____

Patient or Guardian Signature

Patient Authorization

Cancellation Policy

Delmarva PT values spending quality 1-on-1 time with patients. We understand emergencies come up, but please give us more than 24 hours' notice so we can fill that time with another patient.
If cancellations are made less than 24 hours from appointment, the patient will be charged 15 dollars.

Release of Information & Consent to Treatment

I attest to the fact that all information herein is true and correct. I am aware of my diagnosis and wish to receive treatment at Delmarva PT, its subsidiaries, and/or affiliates. I permit its employees to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to Delmarva PT, its subsidiaries, and/or affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided. I authorize Delmarva PT, its subsidiaries, and/or its affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I am aware of The Notice of Privacy Practices for Delmarva PT, its subsidiaries, and/or affiliates. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. Please see associate if you wish to view a copy of The Notice of Privacy Practices

Assignment of Benefits

I authorize payment directly to Delmarva PT, its subsidiaries, and/or affiliates for services and to bill and release payment directly to Delmarva PT, its subsidiaries, and/or affiliates for any physical therapy services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby waive any and all claims against Delmarva PT or any other party for any actions carried out in reliance upon the consent and permission granted herein.

The signature below certifies that I have read and understand the above information.

____ ____________________

Patient or Guardian Signature Date

____

Patient Name Printed

____

Parent or Guardian Name Printed