VITALITY

Spine & Sports Physical Therapy

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PATIENT INTAKE PACKET

Please provide us with all of your important information for billing If you have questions, please ask an administrator purposes. This form is valid for one calendar year. Please inform Vitality PT if any changes need to be done within the calender year. Thank you.

Patient Information Form

Patient Name:			Gender:	DOB:
Marital Status: Single Married Divorced Widow/er	Cell: ( )		Work: ( )	
Address:	City:		State:	Zip Code:
Parent/Legal Guardian Name:	Patient/Parent/Legal Guardian SSN:			
E-mail Address:				

Patient/Guardian Employment Information

Employer's Name:	Occupation:

Emergency Contact: I consent for Vitality PT to share any/all personal health information with my emergency contact.

Name:	Phone:	Relationship to the patient:

Health Insurance Information

Self-Pay - I will not be using health insurance and accept this is my only opportunity to be charged the self-pay rate prior to each treatment: ☐YES, I agree

Primary Insurance:	ID:	Group:
Name of Card Holder:	Card Holder's DOB:	Relationship to the patient:
Secondary Insurance:	ID:	Group:
Name of Card Holder:	Card Holder's DOB:	Relationship to the patient:
Tertiary Insurance:	ID:	Group:
Name of Card Holder:	Card Holder's DOB:	Relationship to the patient:

Have you had Therapy from last October 1st to present? ☐YES ☐ No if YES, Physical#visits________ Occupation#visits________ Speech#visits________

Are you currently receiveing any type of Home Care/Therapy/Hospice? ☐YES ☐NO, If YES, Please provide name of facility and start date:

Facility Name:	Phone: ( )	Start Date:

Do you or legal guardian have a Power of Attorney? ☐YES ☐NO If YES, Name: Phone:

Who can Vitality PT thank for this referral? Friend/Neighbor Spouse Doctor School Advertisement

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By initialing I acknowledge that I have read (or had the opportunity to read) and understood the Notice of Privacy Practice. If a copy is needed for records, I was provided a copy after requesting one from Vitality PT/staff. I understand that Vitality Spine and Sports PT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.__________ INITIAL

CONSENT TO MEDICAL RELEASE

I consent and authorize Vitality Spine & Sports Physical Therapy, LLC to release my medical records to the doctors listed below.

Name of the Doctor:		Phone Number: ( )	
Address:	City:	State:	Zip Code:
Name of the Doctor:		Phone Number: ( )	
Address:	City:	State:	Zip Code:

Patient Signature / Legal Guardian **Date**

Doctor of Physical Therapy
Osteopractor

Rev.04.20.2023

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MEDICAL HISTORY FORM

Please provide us with ALL your health history information. If you do not understand a question, your therapist or an administrator will assist you. If you do not fill out this form appropriately, you the patient can not/will not hold VitalityPT responsible due to any negative consequence / outcome at all as a result of treatment or lack of treatment.

Patient Name: | DOB:

Are you experiencing:
Y / N
☐ ☐ Pain / Discomfort
☐ ☐ Dizziness / Vertigo
☐ ☐ Loss of Balance / Falls
☐ ☐ Stiff / Tight feeling
☐ ☐ Limited fun/life activities
☐ ☐ Burning sensation
☐ ☐ Sharp / Stabbing pain
☐ ☐ Tingling / Numbness
☐ ☐ Weakness
☐ ☐ Limited sports/work
Other(Describe below):

For what problem or body area are you seeking treatment?

Date when did you first notice this problem (approximately): ☐ Unknown

What do you believe caused this problem: ☐ Unknown or Describe

Have you had surgery for this problem? ☐YES ☐NO, If yes, Date of Surgery

Have you been diagnosed with the following?

☐ Cancer / Tumor	☐ Heart Attack	☐ Hepatitis A, B, or C	☐ Parkinson's
☐ Fracture	☐ Heart Failure (CHF)	☐ Anemia	☐ Epilepsy / Seizures
☐ Osteoporosis	☐ Pacemaker	☐ Tuberculosis	☐ Multiple Sclerosis
☐ Osteopenia	☐ Emphysema / COPD	☐ Fibromyalgia	☐ Sleep Disorder
☐ Osteoarthritis	☐ Deep Vein Thrombosis	☐ Concussion / Brain Injury	☐ Depression
☐ Rheumatoid Arthritis	☐ Blackouts / Fainting	☐ Balance Problems	☐ Anxiety
☐ Diabetes II or I	☐ Ulcers / Stomach Problem	☐ Bipolar	☐ Deep Brain Stimulator
☐ Thyroid Problems	☐ Lupus	☐ Autism	☐ Neuropathy
☐ High Blood Pressure	☐ Autoimmune Disease	☐ Schizophrenia	☐ Nerve Stimulator
☐ Stroke / CVA	☐ Asthma or Bronchitis	☐ PTSD	☐ Neurological disease
		☐ TIA	☐ **NONE**

Please list ALL over the counter AND prescription medications that you are currently on for All medical conditions:

Do You Consume:	Current Stress Level:	Any Diagnostic Tests:	Any Treatment:	Your Goals For Therapy:
☐ Alcohol	☐Mild	☐X-Ray	☐ Chiropractor/DO	☐ Reduce Dizziness
☐ Caffeine	☐Moderate	☐MRI	☐ Medication	☐ Better Balance
☐ Cigarettes	☐High	☐CT Scan	☐ Surgery	☐ Reduce Pain
☐Other drugs (list below):	☐Usual	☐Nerve conduction	☐ Acupuncture	☐ Increase motion
	☐Increased	☐None	☐ Injection Date:________	☐ Increase strength
	☐Other:	☐Other:	☐ None	☐ Return to Work / Sports
			☐ Other:	☐ Improve quality of life

Car accident? ☐ Y ☐ N, If yes, Date: ☐At Fault ☐No Fault

Work injury? ☐ Yes ☐ No, If yes, Date:

Are you pregnant? ☐YES ☐NO ☐N/A If yes, How many Weeks?

All Surgeries throughout your life with dates

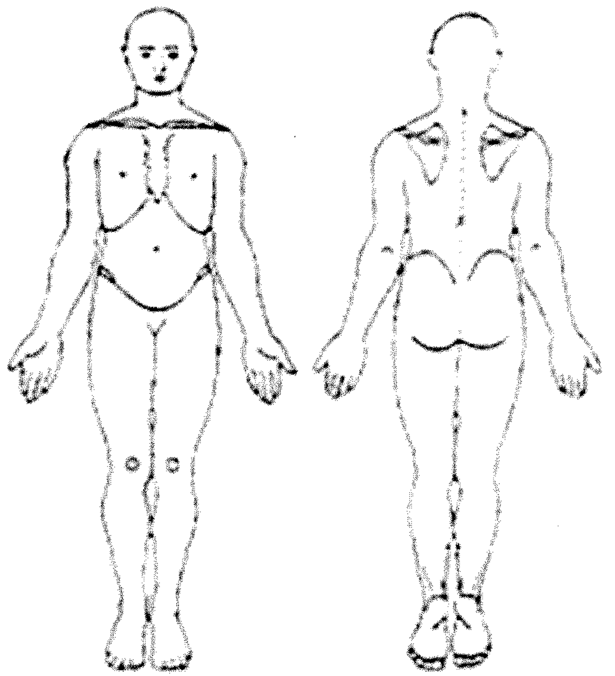
☐ **NO SURGERIES IN MY LIFE**

Y / N	Description	Approx. Date
☐ ☐ Heart		
☐ ☐ Lungs		
☐ ☐ Head / Brain		
☐ ☐ Neck		
☐ ☐ Vein / Vascular		
☐ ☐ Back		
☐ ☐ Abdominal		
☐ ☐ Shoulder / Arm		
☐ ☐ Elbow / Wrist / Hand		
☐ ☐ Hand / Wrist		
☐ ☐ Hip / Knee		
☐ ☐ Leg / Foot / Ankle		
☐ ☐ Cosmetic / Plastic		

Other surgeries:

List any other health problems you feel we need to know about: ☐None or Describe

Please Mark/Shade the Area of Your Problem:



Patient / Legal Guardian Signature Date

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PAYMENT POLICY / PAYMENT AGREEMENT ASSIGNMENT AND RELEASE

I confirm that all information on the previous pages of my Vitality Spine and Sports Physical Therapy (aka Vitality PT) Intake Packet are correct to the best of my knowledge. I understand that myself and/or my dependent, for whom I am totally legally responsible, have health insurance coverage as listed on the Vitality PT Intake Packet and assign directly to Vitality PT all insurance benefit payments, for all physical therapy services rendered. I agree to notify Vitality PT of any changes in my insurance and/or any information provided. I understand that I am totally financially responsible for all charges incurred during physical therapy treatment whether paid or not paid by my insurance. I authorize the use of my signature on all insurance/health information forms for the purpose of collecting payment, insurance information, and medical records/information transfer to other healthcare providers and legal/government entities. Vitality PT will be submitting all claims for patients that have health insurance and will be making a copy of an identification and health insurance card to ensure Vitality PT is submitting the claims to the proper address. I understand that I may not receive a bill for months after my treatment has been rendered. No refunds or exchanges will be given on supplies and/or self-pay services (all sales are final). No refunds will be given for treatment rendered with the exception of overpayment of co-pay, co-insurance, or deductible. All checks must be payable to Vitality PT. A $25.00 charge will made to patients if the check is returned. I have read and understand all the information provided above. I also understand that I am ultimately responsible for the balance of professional services rendered. I understand that I am responsible for any/all of my co-payments/co-insurance, which is due at time of treatment, and any applicable deductible that has not been met for the year. Vitality PT is required by law to bill you and your insurance based on your insurance guidelines. I understand if I do not pay my balance in full that my account will be forwarded to Bill Collection Agent and be charged and extra 33% on top of my balance.

It is my responsibility, as the patient or legal representative of the patient to be aware of my individual plan for physical therapy benefits. It is also my responsibility that if I have any questions regarding my benefits, I will contact my insurance company for clarification/explanation of benefits. Vitality PT is not responsible for explaining your physical therapy benefits. Your insurance company's contract/guidelines with Vitality PT supersede any verbal commitments promises and explanations of your total bill and payment by Vitality PT, staff and/all representatives.

______________________________ ______________________________ ______________

Print Patient / Legal Guardian Name **Patient Signature / Legal Guardian** **Date**

MY COMMITMENT TO EFFECTIVE TREATMENT

At Vitality Spine and Sports P.T., we take your time and treatment seriously. Please read and INITIAL below.

I understand for physical therapy it's important to wear comfortable clothes and shoes that are appropriate to exercise in. ______ Initial

I understand that it is important for the progression of my treatment that I attend all my appointments on time for the full length of treatment that averages 1 hour to 1 hour 15 minutes. ______ Initial

I understand that any missed appointments without proper notice are defined as a cancelled. Appointment without proper notice close of the business day will be subject to a $25.00 fee and will be expected to pay. ______ Initial

I understand that your time and treatment is important to us. In order to be successful with physical therapy I must come to treatment regularly and on time. If I no show and/or cancel for at least 2 appointments with improper notice without a valid excuse, then Vitality PT will start to use "same day" scheduling policy. Same day scheduling is defined as coming to physical therapy the same day I make my appointment and therefore only being able to schedule 1 visit at a time. Also, if I no show for 2 appointments I will be considered administratively discharged and will be referred back to my referring provider/doctor. Only after this I may then restart PT with a new valid referral/prescription for PT and will start "same day" scheduling. ______ Initial

I understand that my health insurance (even worker's comp, attorney's, MVA) does not cover the cancellation fee. ______ Initial

I understand that I will be personally responsible for my own care and my treatment which is my responsibility therefore, third party reschedule / cancellation (spouse/personal assistance) are not acceptable to make any alteration in schedule with the exception of parent/legal guardian or power of attorney. _____Initial

I understand that my insurance company does not cover and is not responsible for the payment of any/all home therapy products and/or supplies as part of my treatment. Therefore, I am fully responsible for the full payment of all products and supplies from Vitality PT. (This includes needles and electrical stimulation pads). ______ Initial

I understand that use of the Vitality PT facility for any purpose in any way is at my own risk and responsibility. ______ Initial

I understand that Vitality PT reserves the right to discharge me at any time and refuse service to anyone. ______ Initial

I understand if I am 15 minutes or later for my appointment without a phone call/ prior communication Vitality PT reserves the right to consider my visit a NO SHOW or CANCELLATION with improper notice and will be subject to a $25.00 fee. ______ Initial

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INFORMED CONSENT TO PLAN OF CARE

Please read prior to initial evaluation and sign AFTER being evaluated.

I (or my parent/legal representative), ________________________________, hereby recognize
(PRINT NAME)
the need for and consent to/request the performance of physical therapy, including various modes of modalities, manual therapy (hands on treatment) and exercises, on me (or on the patient named below, for whom I am legally responsible) by the physical therapist named below and/or other licensed physical therapists/assistants, and any technicians who now or in the future work at Vitality Physical Therapy or office listed below or any other associated office or clinic.

I have had an opportunity to discuss the nature and purpose of physical therapy procedures, theories, education on medical/physical therapy diagnosis and expectations in physical therapy with the physical therapist. It has been made clear to me that there are some risks to treatment, including but not limited to pain, soft tissue/nerve injury, paralysis, fractures, stroke, or death. I do expect the physical therapist/assistant to exercise judgment during the course of the procedure which the physical therapist/assistant feels at the time, based upon the facts known to him or her, is in my best interest.

I understand what is required of me or the patient whom I am responsible for in order to see results for my physical health at Vitality PT. I understand as the patient/ legal guardian that I am required to be on time for my appointments and communicate any changes to my appointment time. I also understand that typical treatment is 2-3x a week for 4-8 weeks. If this is a concern I will discuss this with the Physical Therapist to adjust the plan of care. I understand that the frequency and duration of my treatment depends on what the physician/therapist recommend for the plan of care and nature of your condition. I will communicate with the treating therapist when there are significant changes to my plan of care that include substantial worsening of my condition, changes to my health/medications, improvement in my condition and readiness for progression/discharge. I understand that if I do not communicate these things with my therapist I understand my progress may be significantly limited.

I have read or had read to me, the above consent. I also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my current condition. I understand that any/all results/outcomes of physical therapy are not guaranteed.

Patient Signature / Legal Guardian ____________________________ Date ___________

Physical Therapist ____ Date ___________

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