VITALITY

Spine & Sports Physical Therapy

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WORKER'S COMPENSATION

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:
E-mail Address:			

Patient/Guardian Employment Information

Employer's Name:	Occupation:	Work: ( )

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

Name:	Phone: ( )	Relationship to the patient:

Worker's Compensetion Insurance Information

Insurance Name:	Claim#:	
Adjuster / Case Manager Name:	Pnone: ( )	Fax: ( )

Is your adjuster / case manager aware that your receiving physical therapy with Vitality Physical Therapy? ☐YES ☐NO
If NO, please contact your adjuster / case manager ASAP. This will help your claim go smoothly for you.

Referring Doctor / PCP Name:	Phone: ( )

Are you currently receiving Physical Therapy at a different location? ☐YES ☐NO
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

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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?

Did this happen at work? ☐ YES ☐ NO, if Yes, Date of injury:

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

What do you believe caused this problem: Describe

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
- ☐ Alcohol
- ☐ Caffeine
- ☐ Cigarettes
- ☐ Other drugs (list below):

Current Stress Level:
- ☐ Mild
- ☐ Moderate
- ☐ High
- ☐ Usual
- ☐ Increased
- ☐ Other:

Any Diagnostic Tests:
- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Nerve conduction
- ☐ None
- ☐ Other:

Any Treatment:
- ☐ Chiropractor/DO
- ☐ Medication
- ☐ Surgery
- ☐ Acupuncture
- ☐ Injection Date:_____
- ☐ None
- ☐ Other:

Your Goals For Therapy
- ☐ Reduce Dizziness
- ☐ Better Balance
- ☐ Reduce Pain
- ☐ Increase motion
- ☐ Increase strength
- ☐ Return to Work / Sports
- ☐ Improve quality of life

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

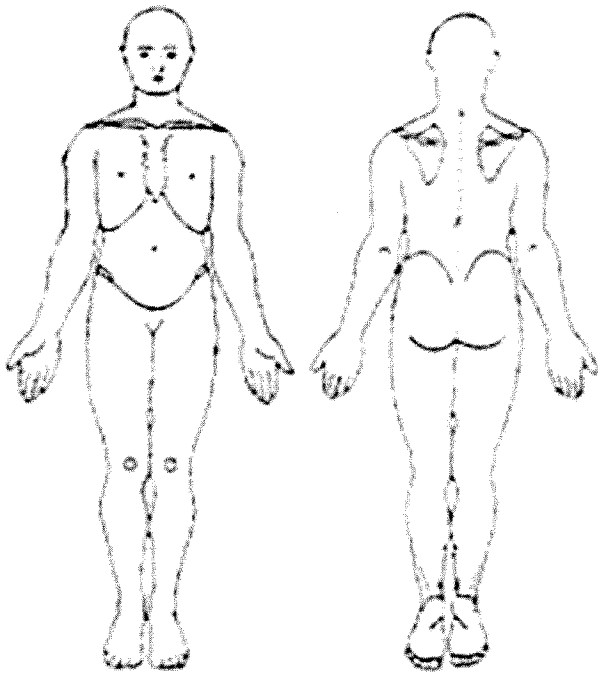
All Surgeries throughout your life with dates:

☐ **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 page of my Vitality Spine and Sports Physical Therapy (aka Vitality PT) Patient Intake Packet are correct to the best of my knowledge.

Worker's Compensation: I understand that I am fully responsible for any/all payments unpaid by Worker's Compensation Insurance even after authorized visits or end dates of authorization have been reached. I understand in the event of the Worker's Compensation Insurance does not cover for my physical therapy visit; I can provider my personal health insurance. This does not mean my health insurance is a guaranteed of payment, but Vitality PT will their best to process your claims. Vitality PT will be making a copy of an identification to have on file. No refunds or exchanges will be given on supplies (all sales are final). 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 if I use my health insurance that I will be responsible for all of my co-payments/co-insurance, 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 ultimately my responsibility to understand and be aware of the worker's compensation / health insurance for physical therapy benefits. It is also my responsibility that if I have any questions regarding my benefits, I will contact my Adjuster/Insurance Company for clarification/explanation of benefits. Vitality PT is not responsible for explaining your physical therapy benefits. Worker's Compensation / health 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 Name	Patient Signature	Date

MY COMMITMENT TO EFFECTIVE TREATMENT

At Vitality Physical Therapy, 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. Vitality PT will notify your Worker's Compensation insurance of the cancelled appointment. _____Initial

I understand that your time and treatment is important to us. In order to be successful with PT 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 and notify Worker's Compensation Insurance. 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 I will be personally responsible for my own care and my treatment which is my responsibility therefore, third party reschedule /cancellation (spouse/personal assistance) is not acceptable to make any alteration in schedule with the exception of power of attorney. _____Initial

I understand that Vitality PT will not bill the Worker's Compensation Insurance 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). I am responsible for providing my receipts to the insurance for reimbursement. _____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 late or more 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 Vitality PT will notify Worker's Compensation. _____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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