COM AQUATICS

PHYSICAL THERAPY & WELLNESS

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INTAKE INFORMATION

Patient Name _____ Date of Birth ___/___/___ Age _____

Today's Date ___/___/___ Occupation _____ Doctor _____

Address: _____

Email address: _____

Primary Phone #: _____ Alternate Phone #: _____

Do you want reminders for appointments? Yes / No If yes, via email, text or phone call? _____

How did you find out about COM Physical Therapy? _____

Emergency Contact Name: _____ phone #: _____

What are your primary symptoms for which you are being seen in physical therapy? _____

_____

When and how did this problem begin? _____

Was this a result of an injury? Yes / No Work injury? Yes / No Gradual onset? Yes / No

When it started ___/___/___ When it became worse? ___/___/___

Please rate your pain from 0-10 (0 = No Pain, 10 = Emergency Room Pain):

Current Pain Rating _____

Least Pain Rating _____ Occurs During _____

Most Pain Rating _____ Occurs During _____

What treatments have you had for this condition? Was it helpful?

- ☐ Physical Therapy Yes / No
- ☐ Chiropractic Manipulations Yes / No
- ☐ Other Yes / No

What are your expectations/goals for physical therapy?

1. _____
2. _____
3. _____

HEALTH HISTORY INFORMATION

Height: _____ Weight: _____

Please check if you have or ever had any of the following:

- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Clots
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Emphysema
- ☐ Kidney Problems
- ☐ On Dialysis
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Lung Problems
- ☐ Muscular Dystrophy
- ☐ Heart Disease
- ☐ Cancer
- ☐ Back/Neck Problems
- ☐ Parkinson's
- ☐ Stroke/TIA
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Head Injury
- ☐ Osteoporosis
- ☐ Heart Attack
- ☐ Neuropathy
- ☐ Dizziness/Vertigo
- ☐ Latex Sensitivity
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Metal Implants
- ☐ Joint Replacement
- ☐ Steroid use
- ☐ High Cholesterol
- ☐ Alcohol consumption if yes, how much_____
- ☐ Smoker or other tobacco products? if yes, daily usage: _____
- ☐ (Allergies, seasonal, other) _____
- ☐ Do you use an assistive device for ambulation or activities of daily living? What type? _____

_____

Recent Surgeries, hospitalizations, or diagnostic testing in the past 12 months (relating to your current condition): _____

_____

_____

ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH SERVICES OR ANY THERAPY ANYWHERE ELSE?

Yes / No WHAT KIND AND WHERE? _____

What are your expectations/goals for therapy? _____

_____

During the past month, have you often been bothered by feeling depressed or hopeless? Yes / No

During the past month, have you been bothered by little interest or pleasure in doing things? Yes / No

REHABILITATION PROGRAM

Following your evaluation, your therapist will discuss your diagnosis, treatment program and plan as well as the potential for improvement and frequency and duration of your program. Normally, treatments can last from 30 minutes to an hour. Please keep your therapist informed of your next doctor visit, preferably at least 2 days prior to the visit, so that we may retest you prior to your visit and share the results with your physician.

Your exercise program will be upgraded as you progress, usually each visit. You may be given a Home Exercise Program. Both programs are vital to your success. The primary goal of the program is to decrease pain, increase flexibility, strength, and endurance, as well as general function. Another goal is to educate you and enable you to return to work, seek employment, or return to your previous level of activity. Please ask any staff member if you need help. Smoking is only allowed outside at least 20 feet from the door entrances. Your appointment time is reserved specifically for you. Should the need arise to reschedule or cancel, your visit please provide 24 hours notice. lf you anticipate arriving later (15 minutes) than your scheduled time please call to see if your appointment needs to be rescheduled.

Patients will be discharged from the program for the following reason(s):

a) Goals are met

b) Compliance problems- exercise absences (no shows), tardiness (>15 minutes), excessive cancellations, or lack of cooperation/poor motivation

c) Lack of Progress

d) Other medical complications

CONSENT FOR CARE AND TREATMENT

l, the undersigned, have read the above rehabilitation program guidelines and do hereby agree and give my consent for COM Physical Therapy to furnish medical care, evaluation, and treatment to (**patient's name**) _____ considered necessary and proper in diagnosing or treating his/her physical and medical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to which l am entitled, including Medicare, private insurance and third party payers to COM Physical Therapy. I understand that COM Physical Therapy agrees to accept the charge determination of the carrier, Medicare as the full charge, and the patient is responsible only for the deductible, co-payment not covered by any supplemental coverage, and any non-covered services including supplies. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize COM Physical Therapy to copy my driver's license to verify that I am the patient receiving the services and to release all information necessary, including Medical Records, to secure payment. I acknowledge that COM Physical Therapy provided me with the opportunity to read a copy of the Notice of Privacy Practices and ask questions.

FINANCIAL POLICY

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly pay.
The above does not apply for those patients that are on an HMO/PPO plan or considered workers' compensation. However, be advised if you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all the costs of collecting monies owed, including court costs, collections agency fees and attorney fees.

When you pay by check and your check is dishonored or returned for any reason, COM Physical Therapy adheres strictly to a policy set forth for dishonored or returned checks and will assess a $25.00 return check fee in addition to the original balance

CANCELLATION AND NO-SHOW POLICY

COM Physical Therapy respectfully requests that any cancellations made are done with 24 hour notice. This allows us to refill your time slot with another person who needs their therapy. Cancellations and no shows are a part of your medical record and will be recorded as such. More than two cancellations or no shows can result in this information being forwarded to your physician and your insurance carrier. lf you are receiving Worker's Compensation, these benefits could be terminated. We realize your schedules are busy and we will do anything possible to accommodate your time requests and rescheduling needs. Your therapist will work with you to schedule your treatment time. lf you have any special needs or concerns, please speak to the clinic manager. Should you ever have a concern or complaint about COM Physical Therapy or your program, please notify your treating therapist. All efforts will be made to meet your needs. I understand that appointments must be cancelled with 24 hours' notice, or I agree to pay a $40 cancellation fee.

Thank you for your cooperation and your consideration for other patients and our staff.

I AGREE to all of the above requirements of COM Physical Therapy

Signature of person completing this form_____

_____Self or, relationship to patient _____ date _____

MEDICATION LIST

Please list all prescriptions, over the counter medications, vitamins or supplements you are currently taking:

Name	Dose	Frequency	How taken: **M**outh, **P**atch, **I**njection, **S**uppository
			M P I S
			M P I S
			M P I S
			M P I S
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