ALANTE PHYSICAL THERAPY & WELLNESS

Patient Intake Form

Date of Call/Registration:

Past Patient ☐Yes ☐No

Patient Information

Last Name/Suffix: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: Email Address:

Date of Birth: SSN: Sex: ☐M ☐F Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Unknown

Employer Information

Employer Name:

Address: City: State: Zip Code:

Work Phone Number: *Patient Occupation/Job Title:* _____

Emergency Contact Information

Contact Name: Phone#: Relationship to Patient: ☐Parent ☐Spouse ☐Other

Name of Referring Physician:
Phone: _____ Fax: _____

MEDICARE ONLY-Additional Questions

If Medicare, are you currently receiving Home Health Service? ☐Yes ☐No If yes, Name of Agency? _____
If yes, what type of Home Health Services are you receiving? _____ Last Date of Service: _____
Are you currently residing in a Skilled Nursing Facility? ☐Yes ☐No If yes, Name of Facility? _____
If Yes, are you on/in the "Medicare Unit"? ☐Yes ☐No
If Medicare, have you received PT, OT, Speech Services since the first of the year? ☐Yes ☐No
*If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐Yes ☐No
*Are you aware of any partial amount used since the first of the year? $_____.
*If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the Information. Please bring the Medicare benefit summary you receive from Medicare.

Insurance Information

Policy Holder Last Name: First Name: Middle Initial: SSN: DOB:

Patient Relationship to Primary Insurance Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____	Gender: ☐ Male ☐ Female
Employer Name:	Employer Phone #:
Primary Insurance Section	**Secondary Insurance Section** Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other
Payor/Plan: Code:	Payor/Plan Code:
Policy/ID#: Group#	Policy/ID# Group#:
Insurance Phone #:	Insurance Phone #:

ALANTE PHYSICAL THERAPY & WELLNESS

Medical History Form

Patient Name: _____ Height: ___ft ___in Weight: ____(lbs) Date of injury: _____

Diagnosis as stated to you by your physician: _____

How did this injury/exacerbation occur? _____

Have you had surgery or been hospitalized for the present condition: ☐ Yes ☐ No If Yes, date: _____

If Yes, surgery type: _____

Have you had any falls this past year? ☐ Yes ☐ No If Yes, how many? _____

Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, date: _____

If Yes, what type of treatment: _____

Have you ever had the following? ☐EMG ☐CT Scan ☐Myelogram ☐MRI ☐X-Ray ☐Other

Have you ever, or are you presently being treated for any of the following conditions?

Sudden Weight Loss	☐Yes ☐No	Allergies	☐Yes ☐No	Osteoporosis	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Heart Trouble	☐Yes ☐No	Hypoglycemic	☐Yes ☐No
Anxiety or Panic Disorders	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Arthritis (RA, OA)	☐Yes ☐No	Stroke or TIA	☐Yes ☐No	Kidney Problems	☐Yes ☐No
Liver/Gallbladder Problems	☐Yes ☐No	MRSA	☐Yes ☐No	Fracture	☐Yes ☐No
Congestive Heart Failure (CHF)	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Metal Implants	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis A, B, C	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Diabetes	☐Yes ☐No	Visual Impairment	☐Yes ☐No	Angina	☐Yes ☐No
Hearing Impairment	☐Yes ☐No	Peripheral Vascular Disease	☐Yes ☐No	Back Injury	☐Yes ☐No
Epilepsy or Seizure Disorder	☐Yes ☐No	Bowel/Bladder Problems	☐Yes ☐No	Asthma	☐Yes ☐No
Are you currently pregnant	☐Yes ☐No	Acquired Respiratory Distress Syndrome		☐Yes ☐No	
Bleeding Disorder	☐Yes ☐No	Chronic Obstructive Pulmonary Disease (COPD)		☐Yes ☐No	

Are you on any medications? ☐Yes ☐No If Yes, please list below or attach list. ☐List Attached

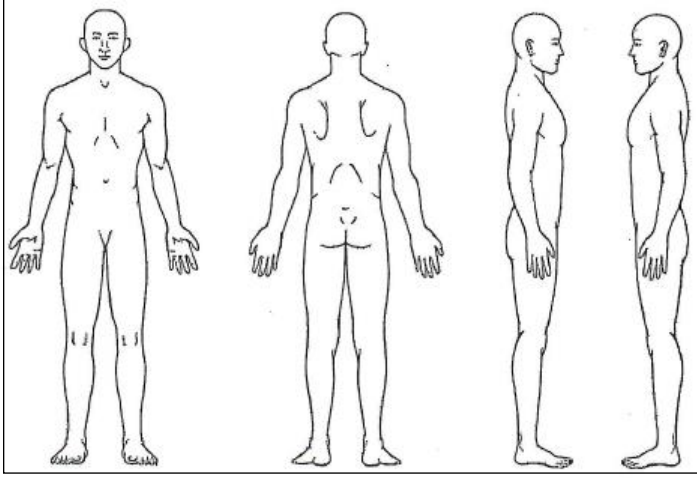
_____

_____

_____

Pain Diagram

Mark your pain over the area of the body as it relates to your present condition



On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its:
best _____ worst _____ current _____

Is there any other information regarding your medical history that we should know about?

_____

_____

_____

What is your goal for therapy at this time?

_____

_____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

ALANTE PHYSICAL THERAPY & WELLNESS

STATEMENT OF FINANCIAL RESPONSIBILITY, CONSENT TO TREAT, AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Date: _____

Alante Physical Therapy & Wellness appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of the bill.

Notification of Patient Responsibility for Co-Payments/Co-insurance % and Deductibles

Your insurance company requires Alante Physical Therapy & Wellness to collect your co-payment amount from you at the time of service. If we do not collect this amount, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. I understand today's charge is ESTIMATED coverage information provided as a courtesy to our patients, but it is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company. Furthermore, we have an obligation to collect any co-insurance % or unmet deductible amounts from you that are determined to be your responsibility. Lymphedema bandaging supplies are generally not covered by insurance and will be billed to you when they are supplied.

If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. You will receive statements from us during and after your treatment for any outstanding amounts your insurance company indicates will be your financial responsibility. These statements will also include the amount billed to your insurance company and the payments received from both you and your insurance company. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience we accept cash, checks, and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the clinic or mailed to the address on your statement.

I have read the above policy regarding my financial responsibility to Alante Physical Therapy & Wellness for providing rehabilitative services to the above-named patient or myself. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Alante Physical Therapy & Wellness. I agree to pay Alante Physical Therapy & Wellness the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by insurance carrier.

Signature: _____ (relationship to patient_____) Date: _____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages, emails or by using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices as applicable.
I/We have read this disclosure and agree that Provider and/or representative may contact me/us as described above.

Signature: _____ (relationship to patient_____) Date: _____

Notification of Authorization to Consent to Treatment

I am aware of my diagnosis and voluntarily consent to have Alante Physical Therapy & Wellness, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Alante Physical Therapy & Wellness is limited to Physical Therapy or Massage Therapy and I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature: _____ (relationship to patient_____) Date: _____

Notification of Authorization to Release Information

I further authorize Alante Physical Therapy & Wellness to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ (relationship to patient_____) Date: _____

ALANTE PHYSICAL THERAPY & WELLNESS

Billing Disclosures to Individuals Involved in Patient's Care

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please complete this section.

I authorize Alante Physical Therapy & Wellness to disclose my health information that is directly related to my current treatment at Alante Physical Therapy & Wellness to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors, friends and colleagues.

Name	Relationship

I DO NOT wish to have my health information disclosed to individuals involved in my care

Name	Relationship

Signature: _____ (relationship to patient_____) Date: _____

LATE CANCELLATION / NO SHOW POLICY

We ask that you please give us the courtesy of a *24-hour* notice to cancel your appointment.
If your appointment is on a Monday please notify us by the previous Friday.
If your appointment follows a holiday on which we are closed please notify us by the previous workday.

Charges for Late Cancellation or No Show are as Follows:
No Show: $75
Cancellations made ***less than*** 24 hours as detailed above: $75
This fee is not billable to insurance

Please note, we always try to fill cancelled appointments and if we are able to do so, you will not be charged the $75 fee. To avoid a possible charge and give other patients the opportunity to be seen, please let us know as soon as possible if you cannot make your appointment.

I have read and understand the Alante Physical Therapy & Wellness Cancellation/No Show Policy.

Signature: _____ (relationship to patient_____) Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given Notice of Privacy Practices for Alante Physical Therapy & Wellness. I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me. I recognize that outside of purposes for treatment, payment, certain healthcare operations or as permitted or required by law I must give my written authorization to Alante Physical Therapy & Wellness to release any of my protected healthcare information.

_____

Patient or Authorized Representative's Printed Name & Date

_____

Patient or Authorized Representative's Signed Name & Date