I CAN PT
DOCTORS OF PHYSICAL THERAPY

Thank you for choosing *I CAN PT*! We look forward to serving you with your rehabilitation needs.
Please read, complete and sign the following intake form to help us better serve you. Thank you.

Patient's First Visit Date	**Physical Therapist's Name**	**Patient's Account Number**
PATIENT INFORMATION		
Patient Name (Last, First, Middle):	**Social Security Number:**	**Date of Birth:**
Mailing Address City, State, Zip Code:		
Marital Status (circle one): Married / Single / Divorced / Widowed	**Sex (circle one):** Male / Female	**Daytime Phone #:**
Patient Email Address:		
COMMUNICATION REQUESTS		
Email: Please note that email communication is not always secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. I CAN PT recommends that with email communication personal information should not be shared (ie: Social Security Numbers, date of birth, etc). However, we understand that emailing is also a beneficial form of communication for scheduling and billing needs and we will accommodate within our means.		
Would you like Appointment Reminders? (circle one): Yes / No	**If Yes, please circle one: Email / Text / Phone Call**	
Would you like Billing Reminders? (Circle one): Yes/No	**If Yes, Please circle one, or both: Email / Text**	
Your Next Physician Visit:	**Primary Care Provider/Doctor:**	**Referring Physician Name:**
Auto Accident? (circle one): Yes / No Date of Accident: State:	**Attorney's Name:**	**Describe Accident:**
Work Related Accident? (circle one): Yes / No Date of Accident:	**Case Manager Name + Phone #:**	**Describe Accident:**
Emergency Contact Name:	**Relation to You:**	**Phone #:**

Are you currently receiving Home Health Care? (circle one): Yes / No	**Home Health Agency Name:**	**Home Health Agency #:**
WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC?		
Return Patient / Location / Physician / Family or Friend /Insurance / Newspaper / Radio / Website / Self /		
Other:		

RESPONSIBLE PARTY (ie. Parent; Guardian; Other)/POLICY HOLDER INFORMATION		
Responsible Party/Policy Holder Name: (Last, Middle, First):	**Phone #**	**Sex: Male / Female**
Address	**Relation to Patient**	
Insured Party's Social Security Number	**Insured Party's Date of Birth**	

EMPLOYER		
Employer's Name	**Employer's Address**	**Employer's Phone #**

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for I CAN PT to furnish medical care and treatment to the above patient as considered necessary and proper in diagnosing or treating his/her physical condition.

[Please Initial]:_____

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, the undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private Insurance and Third Party Payers to I CAN PT. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

[Please Initial]:_____

OFFICE USE ONLY *OFFICE WILL FILL OUT* INSURANCE INFORMATION (Primary & Secondary)

Primary Insurance Plan			**Secondary Insurance Plan**(If Applicable)	
Insurance Name:			Insurance Name:	
Policy Start / End Date	/		Policy Start / End Date	/
Insurance Type (e.g. PPO):			Insurance Type (e.g. PPO):	
ID Number:			ID Number:	
# of PT Visit yr. / Used:	/		# of PT Visit yr. / Used:	/
Deductible Amount / Paid	/		Deductible Amount / Paid	/
PT Co-Insurance %/Co-pay:			PT Co-Insurance %/Co-pay:	
Out of Pocket Max:	/		Out of Pocket Max:	/
Pre Authorization Needed:	Yes / No		Pre Authorization Needed:	Yes / No
Notes:			Notes:	

PROTECTED HEALTH INFORMATION RELEASE: FOR PATIENTS 18 YEARS AND OLDER (VERBAL ONLY)

***Check all applicable boxes and fill any blank spaces as necessary**

☐ Only Release Information to me personally

☐ You have my permission to speak with my Spouse/Significant Other about my medical care/to schedule:
Spouse/Significant Other Name: _____ Phone: _____

☐ You have my permission to talk with my children, other family members or close contacts, involved with my medical care/to schedule:

Name _____ Phone: _____

Relationship _____

Name _____ Phone: _____

Relationship _____

☐ You have my Permission to leave information on my voicemail/answering machine regarding my medical care/to schedule.

☐ Other (Please Describe): _____

PATIENT'S FINANCIAL RESPONSIBILITY

Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities as a patient and eliminate any unnecessary confusion. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement. Adhering to these policies will enable us to focus increased attention on providing quality rehabilitative services to our patients and run our clinic more efficiently.

The estimate of benefits I CAN Physical Therapy receives from your insurance may not be accurate. Your insurance coverage and the information provided is a courtesy to our patients, but are not intended to release you from total responsibility for your account balance. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of claims is subject to all terms, conditions, limitations, and exclusions of the patient's insurance plan at the time of service.

Your insurance provider may require you to pay a deductible and/or Co-Pay/co-insurance payment for Physical Therapy services received. Your insurance provider requires I CAN Physical Therapy to collect and report deductible, Co-Pay and/or Coinsurance payment. We request payment of copayment, deductibles and coinsurances at the time of visit upon check-out. If this is not possible please discuss this with the staff before services are rendered. If insurance reimburses more than the billed amounts we will reimburse you after all your claims have been processed by insurance.
If your insurance company does not remit payment within 60 days, the balance may be due in full from you. Once insurance remits payment to I CAN PT, a refund check will be issued to you.

WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENT: It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. If we do not have the verifiable billing information before your second appointment, your therapy will continue either on a cash basis until we receive the necessary billing information pertaining to your injury, or we will ask for your private insurance information. If, for any reason, your claim is denied, we will attempt to bill your private insurance, but please understand that ultimately you are responsible for full payment. Any attorney "letter of protection" for claims being disputed or in litigation will be discussed on a patient-by-patient basis and will not always be an acceptable form of payment guarantee. If that is the case we will need alternate insurance information or transfer your account to a cash pay basis. If your claim is in a "deferred" status we will need to have private insurance information on file in the event your claim is denied or pending litigation.

UNINSURED PATIENTS: We believe that no one should be denied physical therapy services secondary to not having insurance. Our clinic offers a discounted cash rate to those who do not have insurance coverage. Payment will be required at the time of service unless arrangements are made in advance. Please inquire about our current cash pay rate if it is applicable to your situation.

We are very sensitive to your individual financial constraints. If necessary, we encourage patients to contact our billing staff to arrange an acceptable payment schedule.

PLEASE NOTE: An outstanding balance of 90 days will be sent to an outside agency for collections, unless payment arrangements are made, and kept.

PLEASE CIRCLE ONE: I will be using a: Health Savings Account/Flexible Spending Account/Not Applicable.

I have read the patients responsibility information above and **I UNDERSTAND MY FULL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT**.[Please Initial]:_____

PAST MEDICAL HISTORY – Please check all that apply and specify as needed

- ☐ Osteoarthritis: _____
- ☐ Cardiovascular Disease: _____
- ☐ **Pacemaker**
- ☐ Currently or Previously had the Shingles Virus. If checked, what is estimated date of onset? _____
- ☐ Currently Pregnant
- ☐ High Blood Pressure
- ☐ Fibromyalgia
- ☐ Seizures:_____
- ☐ Diabetes: _____
- ☐ Psycho-Social Disorders: _____
- ☐ Respiratory Disorders: _____
- ☐ History of Cancer: _____
- ☐ Tobacco / Alcohol / Substance Abuse or Dependence: _____
- ☐ Vision / Hearing Deficits: _____
- ☐ Allergies: _____
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ **Deep Brain Stimulator**
- ☐ **Bone Stimulator**
- ☐ Alzheimer's / Dementia
- ☐ Other:_____

MEDICATIONS (Prescription and Over-the-Counter)

Please provide a complete and current list of all medications. You may bring a copy from home for us to scan.

SURGICAL HISTORY – Specify area, procedure and date

ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of I CAN PT's Notice of Privacy Practices.	[Please Initial]:_____
I understand that a patient's health information (PHI) is private and confidential. I understand that I CAN PT LLC has procedures to protect a patient's privacy and preserve the confidentiality of every patient's PHI. I will assist I CAN PT by following these if I choose to exercise any of my rights described in the "Notice of Privacy Practices".	[Please Initial]:_____
I agree to the open treatment area used by I CAN PT and understand that a private treatment area may not be available.	[Please Initial]:_____
I agree and understand that other patients will be completing treatment plans during my visit and may overhear information regarding my plan of care.	[Please Initial]:_____
I agree that Physical Therapist/Physical Therapist Assistant/Observing student may be present and/or assist in my care.	[Please Initial]:_____
I agree that I CAN PT employees may call my home in regard to my health status.	[Please Initial]:_____
I agree that I CAN PT may use my home and/or email address to send receipts, home exercise programs, appointment reminders and newsletters.	[Please Initial]:_____
☐ **Check if you wish to refuse to sign the above Acknowledgement**	

APPOINTMENT CANCELATION / NO-SHOW POLICY
Your "Plan of Care" has been prescribed by a Doctor of Physical Therapy. Executing this "Plan of Care" as prescribed is critical in reaching our combined goals. Canceling your appointment impacts your success of rehabilitation. Please do not cancel unless 100% necessary. **To provide all our patients with the best care we can only allow a maximum of 3 cancellations, or 1 no show, during your episode of care. If you cancel without giving 24-hour notice, a $25 cancel fee may be charged to your account. Be prepared to pay the fee on your next visit; we cannot bill insurance for cancellation fees.** I have read and agree to the policy above: [Please Initial]:_____

I, the undersigned, acknowledge and agree to the above information in this form in its entirety and by signing below, agree that the information I have provided is accurate and current to the best of my knowledge.

X_____ _____

Patient or Guardian's Signature Print Name Date

New Insurance reporting guidelines require the following questions to be recorded, please answer honestly to the best of your knowledge.

Please Indicate your height in inches and weight in pounds.

Height _____ Weight_____

Choose the best answer for how have you felt over the past week:

1. Are you satisfied with your life? Yes/No
2. Have you dropped many of your activities and interests? Yes/No
3. Do you feel that your life is empty? Yes/No
4. Do you often get bored? Yes/No
5. Are you in good spirits most of the time? Yes/No
6. Are you afraid that something bad is going to happen to you? Yes/No
7. Do you feel happy most of the time? Yes/No
8. Do you often feel helpless? Yes/No
9. Do you prefer to stay at home rather than going out and doing new things? Yes/No
10. Do you feel you have more problems with memory than most? Yes/No
11. Do you think it is wonderful to be alive now? Yes/No
12. Do you feel worthless the way you are now? Yes/No
13. Do you feel full of energy? Yes/No
14. Do you feel that your situation is hopeless? Yes/No
15. Do you think that most people are better off than you are? Yes/No