



Patient Intake Form

Name: _____ Referral Date: _____ Height: _____ Weight: _____

Address: _____ City: _____ State & Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ E-mail: _____

In case of emergency, contact: _____ Phone: _____

How did you hear about us: _____

Have you received any home health care within the past six months? YES _____ NO _____

Referring Physician: _____ City: _____ Phone: _____

Is there someone else that you would like us to send this information to?

Physician: _____ City: _____ Phone: _____

Diagnosis / Complaint: _____

RESPONSIBLE PARTY / PARENT / LEGAL GUARDIAN (if applicable)

Name: _____ Relationship: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ State & Zip: _____

EMPLOYER INFORMATION

Employer Name: _____ Occupation: _____

Address: _____

Phone: _____ Contact Person: _____ Attorney: _____

PAST SURGERIES

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

PAST CONDITIONS / DISEASES / INJURIES / INFECTIONS

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

OTHER INFORMATION

Allergies: _____

Date of last pelvic / prostate exam: _____ Results: _____

Date of last mammogram: _____ Results: _____

Date of last dexascan / bone density test: _____ Results: _____

Date and results of any other recent tests: _____

Activity level / work / hobbies: _____

Severity of this condition (0=NO PROBLEMS – 10=UNBEARABLE): _____

Your goal from therapy: _____



PATIENT SERVICES AGREEMENT

PATIENT NAME: _____

RELEASE OF INFORMATION: I authorize Kirk Integrative Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

PERMISSION FOR MESSAGES: I authorize Kirk Integrative Physical Therapy to leave messages -

About my treatment:

- on my voicemail or answering machine at my home on my voicemail on my cell phone
 on my voicemail at my work with another person

About my appointment times:

- on my voicemail or answering machine at my home on my voicemail on my cell phone
 on my voicemail at my work with another person

I have read this agreement and understand my obligations

Patient Signature

Date

Patient Address

Preferred Phone



DOCUMENTATION OF CURRENT MEDICATIONS

Use the below grid to document your current list of medications. This list **must** include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration (oral, topical, suppository, inhalant, intravenous).

<i>Medication / Supplement</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Route of Administration</i>

I do hereby attest that this information is true, accurate and complete to the best of my knowledge.

_____ *Patient/Guardian Signature*

_____ *Date*

I have reviewed the above current medication list with the patient/guardian and it is to the best of my knowledge accurate as of the below signed date.

_____ *Physical Therapist Signature*

_____ *Date*



CREDIT CARD AUTHORIZATION – (OPTIONAL)

I authorize Kirk Integrative Physical Therapy, PC, to bill the following credit card for services or missed appointments. I understand that if my credit card is declined, a \$50.00 fee will be posted to my account.

Name of Patient

This authorization is to remain in effect until I cancel it in writing.

The payments I am authorizing are:

- Account delinquency of 75 days
- Monthly balance billing
- Each Visit

For your convenience we accept personal checks, **Visa, MasterCard, Discover and Amex.**

Card Type	Card Number	Expiration Date	CVV Code
Visa			
MasterCard			
Discover			
Amex			

Name as it appears on the card: _____

Authorized Patient/Guardian/Cardholder's Signature: _____

Billing address on file with credit card:

Street Address: _____

City / State / Zip: _____

Date: _____



Cancellations and No-shows Policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

Cancellations

- We require 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind, preferably in the same week, that will ensure you get in the full prescribed number of treatments.

No-shows

- A no-show is a missed appointment without notice.

Charges

Any cancellation less than 24 hours' notice or no-show will be charged as the following:

- Adult evaluation of 1.5 hours: \$250
- Adult treatment session of 1 hour: \$165
- Child evaluation of 1 hour: \$165
- Child treatment session of 30 minutes: \$85

Full payment of the above charge is due at your next scheduled appointment.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Thank you for cooperating with us in this regard. We are looking forward to working with you.

Patient/Guardian Signature

Date

Interviewer Signature

Date