CAROLINA STRONG PHYSICAL THERAPY INTAKE FORM

Name: _____ Date of Birth: _____ SSN:_____-____-_____
(as it appears on insurance card) *veterans only*
Email address: _____
Street Address: _____
Preferred Phone: _____ Secondary Phone: _____
Primary Care Physician: _____

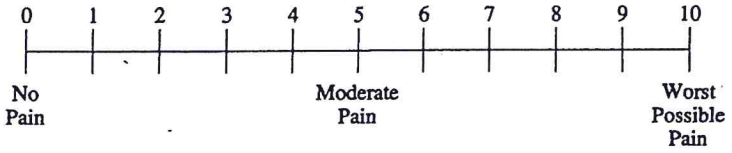
Do you have a pacemaker? _____ Are you currently pregnant? ____ Allergies: _____
Current Medications: _____

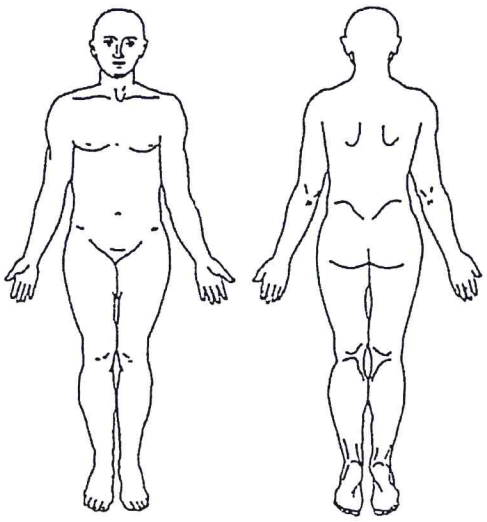
Have you ever been diagnosed with the following? (CIRCLE all that apply)

☐ Anemia	☐ Circulation Problems	☐ Osteoarthritis/Rheumatoid
☐ Asthma	☐ Diabetes	☐ Parkinson's Disease
☐ Atrial Fibrillation	☐ Fibromyalgia	☐ Pneumonia
☐ Bone/Joint Infection	☐ High/Low Blood Pressure	☐ Seizures
☐ Cancer	☐ Lung Disease/COPD	☐ Stroke/TIA
☐ Congestive Heart Failure	☐ Multiple Sclerosis	Other _____

Briefly describe your symptoms: _____
Date of injury/surgery: _____ Is condition related to ☐ Auto accident ☐ Work
What are you having difficulty with? _____
What is your goal for physical therapy? _____
Recent imaging ☐ X-ray ☐ MRI ☐ CT scan

0-10 Numeric Pain Intensity Scale





Please use the diagram to mark your symptoms

My symptoms are made better by: _____

My symptoms are made worse by: _____

My symptoms are ☐ Constant ☐ Intermittent

My symptoms are waking me up at night ☐ Yes ☐ No

My symptoms are:
☐ Stabbing ☐ Sharp ☐ Sore ☐ Aching/Dull ☐ Numbness
☐ Tingling ☐ Throbbing ☐ Pinching ☐Burning

Carolina Strong
PHYSICAL THERAPY

General Consent

- I consent to medical treatment and care at this facility.
- I agree this facility is not responsible for any loss or damage of my property.
- I am aware that healthcare is not an exact science and no guarantees have been made.

Financial Responsibility

- I agree to pay for all medical services provided.
- I understand that I may need to call my insurance company to see if they will approve and pay for the medical care including any **co-pay**.
- Please bill my health insurance plan as a service to me. I am aware that this does not mean they will agree to pay for any services. I agree to pay whatever amount is not covered.
- I assign all my rights and claim for payment under any health insurance plan to Carolina Strong Physical Therapy.
- I appoint Carolina Strong Physical Therapy as well as other treating providers and/or their agents as my "Authorized Representative" to act for me in getting payment for services provided.
- I give permission to be called on any of the telephone numbers I have given. Calls may be made by businesses helping my provider collect money that I owe.

Acknowledgement of Receipt of Notice of Privacy Practice

HIPPA Notice of Privacy Practices

- I have been provided with a copy of Carolina Strong Physical Therapy's Joint Notice of Privacy Practices.
- I know that the notice may be changed at any time.

Notice of Cancellation/No Show Fee

As of February 25, 2019, if you have to cancel your appointment you must do so 24 hours prior to your scheduled appointment. If you do not give us 24-hour notice there will be a **$25.00** cancellation fee. The **$25.00** fee also applies if you no show for an appointment. We also realize that there are exceptions such as illness and emergencies. In these circumstances you will NOT be charged the above fee. If you no show/late cancel 3 appointments within the same treatment plan, the remainder of your scheduled visits will be canceled unless other arrangements have been agreed upon.

I understand and agree with the above information.

Patient/Responsible Party (if patient is under 18):

Signature: _____ **Date:** _____

Print Name:_____

Carolina Strong
PHYSICAL THERAPY

Patient Payment Policy

The staff of Carolina Strong Physical Therapy are committed to providing the highest quality care to our patients. In order to do this, we must maintain excellence in the clinic, as well as our business office and other areas of the practice.

The purpose of this policy is to provide guidelines and specific instructions related to gathering and maintaining accurate patient information, billing for services rendered and efficient collection activity. Please note these instructions may be modified periodically to ensure we maintain efficient and appropriate protocols related to the business office functions.

It is the patient's/parent's/guardian's, responsibility to be familiar with the benefits of your insurance plan, including co-pays, co-insurance and deductibles. We will file your insurance, but please be aware that payment for services is ultimately your responsibility.

For your conveniences, we accept cash, check, Visa, Mastercard, and Discover

Any payment made by check that does not clear your bank account will result in a $25.00 returned check fee, which will be added to your account and must be paid before the next visit.

Insurance and Patient Identification

Verification of insurance will be done when we schedule your first appointment for physical therapy. Please be sure to have checked with your provider (insurance carrier) if we are in your network and what your co-pay will be. We will also make a copy of your insurance card(s) and valid ID and address information.

Co-pays

In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. **We collect co-pays at check in.**

Self- Pay

If you do not have insurance or choose to self- pay, you will be responsible to make a complete self- pay payment each visit. Our fees are $100.00 for the initial visit and $75.00 thereafter.

I have read and understand the Carolina Strong Physical Therapy Payment Policy.

_____ _____

Patient's Signature Date

_____

Print Name