CAMPUS COMMONS
PHYSICAL THERAPY

Today's Date_____ **Staff Initials:**_____ **Date of IE:**_____ **P.T.**_____

Patient Name:: (First) _____ (Last) _____(M.I.)_____

Address: _____City:_____ State: _____ ZIP: _____

Date of Birth: _____/_____/_____Age: ____ SSN: _____Sex: _____F _____M

Cell Ph: _____Work Ph: _____ Home Phone: _____

Email Address: _____ May We Send Emails to the address? ____ Y ____ N

Would you like text message appointment reminders? ____Y ____N

Employer: _____ Occupation:_____

Is this a work injury? ____Y ____N Is this due to auto accident? ____Y ____ N

Is a nurse or medical professional coming to your home to provide care or assistance of any kind? ____Y ____N

If yes, what are you receiving care or assistance for at home? _____

Emergency Contact: _____ Phone: _____

Referring Doctor: _____ Date of Referral: _____Date of Injury:_____

How did you hear about us? ___MD ____Returning Patient ____Family/Friend ____Other_____

PATIENT PRIVACY NOTICE

We are required by law to maintain the privacy of your healthcare information. Campus Commons Physical Therapy understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. HIPAA policies are available upon request in print form.

CONSENT TO TREAT

I give permission for Campus Commons Physical Therapy to provide the medical treatment appropriate and necessary for the rehabilitation of my or my dependent's current physical condition.

I agree to and understand the above policies:

_____ _____ _____

Patient / Parent / Guardian Signature **Printed Name** **Date**

PAYMENT OPTIONS – CREDIT CARD ON FILE

For your security and protection, Campus Commons Physical Therapy stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.
I authorize Campus Commons Physical Therapy to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and missed visit fees.
I understand that I can update my card information on file at any time by contacting Campus Commons Physical Therapy's office directly. I understand that it is my responsibility to notify Campus Commons Physical Therapy of any updates or changes to the credit card on file associated with this agreement as soon as possible.
Please check your preference below and initial next to it:

___Yes, I would like my credit card information securely stored on file. _____ Initials

___No, I do not want my credit card information securely stored on file. _____Initials

INSURANCE

Your insurance coverage is a contract between you and the insurance company and we are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. As a courtesy to you, we will verify your insurance benefits and eligibility prior to your evaluation. As a courtesy, we will submit your claims to your primary and secondary insurance companies. If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.

If your insurance company requests any information from you, it is your responsibility to complete the request immediately with your insurance company. If you do not complete their request and they deny payment, you are responsible for the billed amount for all denied services.

If your policy or insurance company changes and you fail to inform us, any visits that may not be authorized or your new insurance company does not cover charges that are incurred, you will be responsible for those charges.

RESPONSIBILITY FOR AMOUNT DUE

Payment of copays and deductibles will be due at time of service. Our failure to collect these amounts may be a violation of our contract with your insurance company. You are ultimately responsible if your insurance denies a claim for any reason. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Director of Administration or Owner. Anything over 30 days is considered past due.
If you do not have insurance, we have self-pay options and payment in full will be due at time of service or if purchasing a physical therapy service package, payment is due in full when purchasing the package.

I hereby give authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees, I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

_____	_____	_____
Patient / Parent / Guardian Signature	**Printed Name**	**Date**

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Missed Visit Policy

At Campus Commons Physical Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, we require a day's notice – **we need you to contact our office by 4:00pm the day before so we have enough time to help someone else who needs an appointment time.**
6. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
7. Same-day cancellations and appointment no-shows are not permitted as they keep other patients from getting the care they need.
8. There is a **$50.00 fee if you do not provide at least a day's notice of your appointment change or cancellation. This is non-negotiable and it's your responsibility as insurance will not cover it.**
9. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment. We need you to contact our office the day before by 4:00pm.
10. **To avoid our missed visit fee, call our office during business hours – by 4:00pm the day before, for any illness, appointment changes or cancellations.**
11. Patients who have multiple same-day cancellations or no-shows, will be removed from the schedule. We will also notify your physician of your non-compliance.
12. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show.

We look forward to working with you to meet your physical therapy goals.
Mark Eddy, Owner

I have read this policy and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

Staff Initials_____/ Date_____

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Medical History

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

What is the reason for your visit today?_____

Describe any previous treatment for the condition we are seeing you for today. _____

Have you had any tests for this current problem? (**please circle**): X-Ray MRI CT Scan Lab Work Other:_____

Do you have a previous injury or condition that may affect your treatment? _____

Have you fallen two times or more in the last year, or had any fall resulting in an injury? YES NO
YES, Explain: _____

Currently, I am experiencing the following? (Circle all that apply)

Unexplained Weight Loss/Gain	Falls/Loss of Balance	Headaches	Shortness of Breath
Loss of Consciousness/Fainting	Changes in appetite	Numbness / Tingling	Dizziness
Changes in bowel/bladder function	Nausea / Vomiting	Fever / Chills	Night Sweats

Please list past surgeries and dates: _____

_____

Do you exercise?	YES / NO	Do you wear glasses/contacts?	YES / NO
Do you use alcohol?	YES / NO	Are you pregnant?	YES / NO
Do you smoke?	YES / NO	Do you have difficulty hearing?	YES / NO

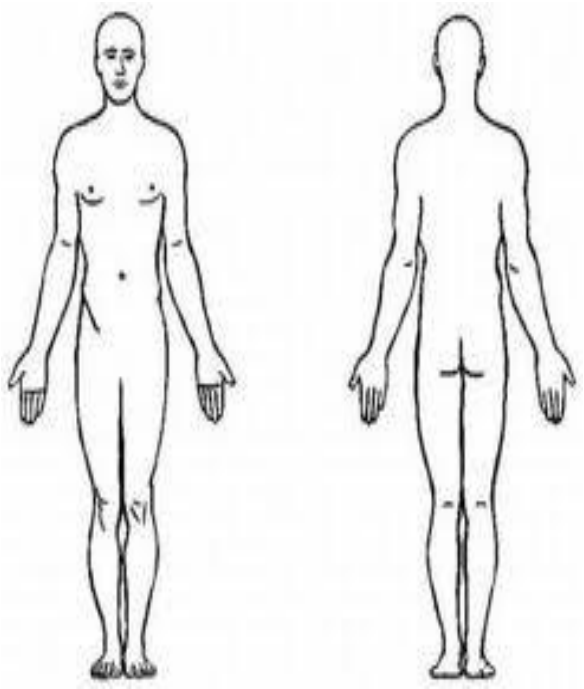
Please indicate (**X**) if you have or have ever had any of the following:

_____ Cancer(type):_____
_____ Pacemaker/Heart disease
_____ Blood Pressure Problems
_____ Circulation Problems
_____ Asthma/Lung Disease
_____ Stroke
_____ Nervous Disorder
_____ Seizures
_____ Diabetes
_____ Osteoporosis
_____ Kidney Disease
_____ Rheumatoid Arthritis
_____ Other Arthritic Conditions
_____ Allergies
_____ Anemia
_____ Thyroid Problems

Please explain and give approximate dates for any item indicated above: _____
_____

Please indicate on the body chart below the symptoms you are having:

Numbness/tingling: XXXX **Burning Pain: OOOO**
Dull/Aching Pain: ==== **Sharp Pain: ////**



Please circle the pain intensity when you feel the BEST, and when you feel the WORST (0 = no pain, 10 = worst pain imaginable)

Pain at best = 0 1 2 3 4 5 6 7 8 9 10
Pain at worst = 0 1 2 3 4 5 6 7 8 9 10

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Medication List

Please include prescription, over-the-counter, herbals, and supplements.

Please indicate how medication is taken if not taken orally. Thank you!

Patient Name:_____ Date: _____

Patient Signature:_____

☐ No Medications

☐ See attached list

	Medication:	Dose:	Frequency:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____

Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES☐NO☐Do you have a pacemaker or any other implanted devices?

YES☐NO☐Are you pregnant?

YES☐NO☐Do you have cancer?

YES☐NO☐Are you taking medications that may increase your sensitivity to light?

YES☐NO☐Have you had a steroid injection in the last 7 days?

Patient Signature _____ Date _____

Print Patient Name _____

Notes:

The ultimate decision to recommend treatment lies with your healthcare provider.
Speak with your healthcare provider if you have further questions about therapy treatment.