ONPOINT PHYSICAL THERAPY

Patient Intake Information

PATIENT INFORMATION				
FIRST NAME:	LAST NAME:		M.I.	DATE: / /
ADDRESS:	CITY:		STATE:	ZIP:
BIRTHDATE: / /	AGE:	SEX:	S.S. #:	EMAIL:
HOME PHONE:	ALT PHONE:		MARITAL STATUS:	
REFERRED BY: ☐ DR:	☐ WEBSITE:	☐ FRIEND:	☐ WALK-IN	

WORK INFORMATION		
EMPLOYER:	WORK PHONE:	EXT:
OCCUPATION:	WORK STATUS: ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED	

CARE PROVIDER INFORMATION	
REFERRING DR:	REFERRING DR PHONE:
PRIMARY CARE PHYSICIAN:	PCP PHYSICIAN PHONE:

INSURANCE INFORMATION	
PRIMARY INSURANCE NAME:	
SUBSCRIBER'S NAME (IF DIFFERENT):	BIRTHDATE:
ID NUMBER:	GROUP NUMBER:
RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	
SECONDARY INSURANCE NAME:	
SUBSCRIBER'S NAME (IF DIFFERENT):	BIRTHDATE:
ID NUMBER:	GROUP NUMBER:
RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE AS SECONDARY/ BACKUP)			
INSURANCE NAME:	☐ AUTO ☐ LABOR/ INDUSTRIES		
ADJUSTER/CLAIM MANAGER:	PHONE:	EXT:	
ADDRESS:	CITY:	STATE:	ZIP:
CLAIM NUMBER:	ACCIDENT DATE: / /		

ATTORNEY INFORMATION			
NAME:	LAW FIRM:	PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:

EMERGENCY CONTACT INFORMATION: (PERSON NOT LIVING WITHIN SAME HOUSEHOLD)	
NAME:	RELATIONSHIP TO PATIENT
PHONE:	ALT PHONE:

I authorize my insurance benefits be paid directly to OnPoint Physical Therapy. I understand that I am financially responsible for any remaining balance. I also authorize OnPoint Physical Therapy to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE DATE

ONPOINT PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

PATIENT NAME:

BLOOD PRESSURE	YES	NO
HYPERTENSION		
LOW BLOOD PRESSURE		
NORMAL BLOOD PRESSURE		

HEART DISEASE	YES	NO
HEART ATTACK		
ATHEROSCLEROTIC DISEASE		
PACEMAKER		
HEART MURMUR		

MUSCLE CONDITIONS	YES	NO
CARPAL TUNNEL R / L		
TENNIS ELBOW R / L		
BACK/ NECK PROBLEMS		
LIMITED LIMB MOVEMENT		

LUNGS	YES	NO
ASTHMA		
EMPHYSEMA		
SHORTNESS OF BREATH		

JOINT CONDITIONS	YES	NO
SHOULDER/ELBOW/WRIST PROBLEMS		
SPINE PROBLEMS		
HIP/ KNEE/ ANKLE/ FOOT PROBLEMS		

OTHER CONDITIONS	YES	NO
MUSCULAR DYSTROPHY		
RHEUMATOID ARTHRITIS		
MULTIPLE SCLEROSIS		
EPILEPSY		
FIBROMYALGIA		
DIABETES		
HEARING LOSS		
POOR EYESIGHT		
FAINTING		
POLIO		

OTHER: _____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ NONE	☐ SITTING	☐ LOW	☐ SMOKING	PACKS A DAY ____
☐ 1-2 x WEEKLY	☐ STANDING	☐ MEDIUM	☐ ALCOHOL	DRINKS PER WEEK ____
☐ 3-4 x WEEKLY	☐ LIGHT LABOR	☐ HIGH	☐ COFFEE/ SODA	CUPS PER WEEK ____
☐ 5+ x WEEKLY	☐ HEAVY LABOR			

WHAT TYPES OF EXERCISE DO YOU PERFORM? _____

WHAT THINGS CAUSE STREES IN YOUR LIFE?

ARE YOU TAKING ANY SEIZURE MEDICATION? YES / NO IF YES, NAME: _____

ARE YOU TAKING ANY MEDICATIONS THAT MIGHT AFFECT YOUR WELL-BEING WHILE PARTICIPATING IN THERAPY? YES / NO

LIST ALL CURRENT MEDICATIONS: _____

LIST ALL ALLERGIES: _____

LIST ALL SURGERIES (INCLUDING DATES) WITHIN THE LAST 2 YEARS: _____

ARE YOU PREGNANT YES / NO IF YES, WHAT WEEK: _____

HAVE YOU HAD ANY INJURIES RELATED TO WORK? YES / NO IF YES LIST BODY PART AND DATE: _____

HAVE YOU HAD ANY AUTO ACCIDENTS? YES / NO IF YES LIST BODY PART AND DATE: _____

HAVE YOU PREVIOUSLY HAD PHYSICAL OR MASSAGE THERAPY BEFORE: YES / NO

IF YES, LOCATION AND DATES:

_____

SIGNATURE OF PATIENT OR PARENT/ GUARIDAN DATE

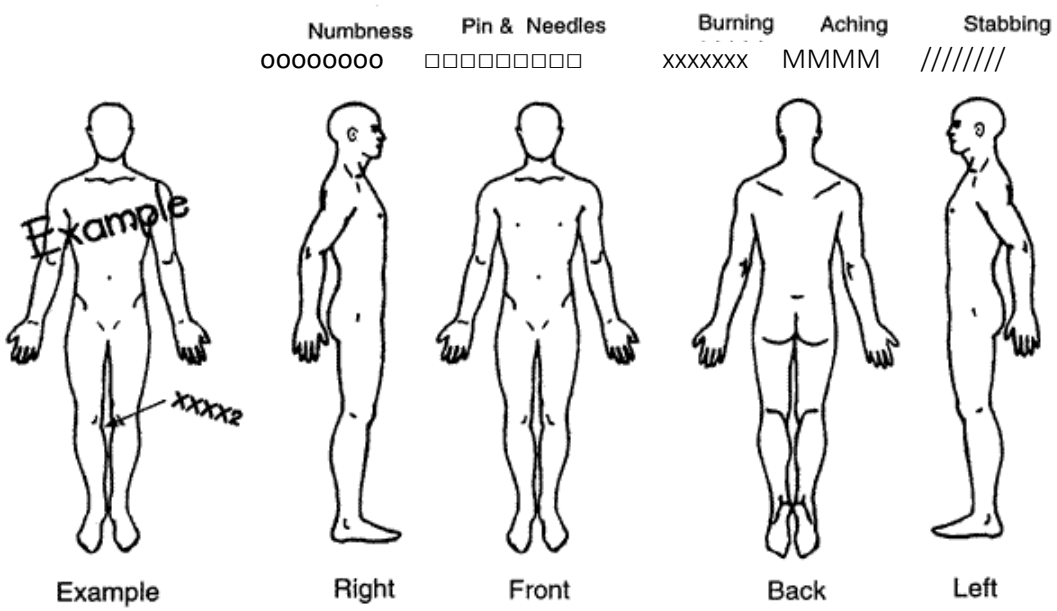
_____

SIGNATURE OF PHYSICAL THERAPIST DATE

ONPOINT PHYSICAL THERAPY

PAIN AND SYMPTOM STATUS REPORT

NAME: _____ DATE: _____



CHIEF COMPLAINT AND VISUAL ANALOG SCALE

MY CHIEF COMPLAINT IS: _____

DATE FIRST SYMPTOM OCCURRED: _____

2ND COMPLAINT: _____

3RD COMPLAINT: _____

PLEASE CIRLCLE ON THE SCALE BELOW YOUR **CURRENT** LEVEL OF PAIN:											
NO PAIN	1	2	3	4	5	6	7	8	9	10	AS BAD AS IT GETS
PLEASE CIRLCLE ON THE SCALE BELOW YOUR **AVERAGE** LEVEL OF PAIN:											
NO PAIN	1	2	3	4	5	6	7	8	9	10	AS BAD AS IT GETS
PLEASE CIRLCLE ON THE SCALE BELOW YOUR **WORST** LEVEL OF PAIN:											
NO PAIN	1	2	3	4	5	6	7	8	9	10	AS BAD AS IT GETS

Onpoint Physical Therapy
4817 E Douglas, Suite 200
Wichita, Kansas 67218
Telephone: (316) 260-2424
Fax: (316) 260-2426

NO CALL NO SHOW POLICY

We kindly request that any patient who needs to cancel or rebook an appointment shall call this office at least 24 hours before the scheduled appointment time. This will allow us ample opportunity to offer the appointment time to another patient.

Due to an overwhelming amount of repeat no-shows, we have put into place a policy that charges Service fees for that particular date of service.

Please note: This fee is **NOT** covered by private party health insurance or workers' compensation benefits

By signing this agreement I acknowledge that I fully understand the above stated policy.

_____ _____

Patient/ Parent/ Guardian Signature Date

HIPPA NOTICE

ACKNOWLEDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and/or reviewed a copy of the Onpoint Physical Therapy, Inc. Notice of Practices within the effective date of 4/23/2003.

Signature of Patient / Parent/ Guardian

Date

Relationship to Patient

CONSENT FOR TREATMENT

I, _____ , DO HEREBY GIVE CONSENT FOR ***ONPOINT PHYSICAL THERAPY*** TO FURNISH MEDICAL
PATIENT / PARENT / GUARDIAN
CARE AND TREATMENT TO _____ .
PATIENT NAME AND DATE

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I HEREBY ASSIGN TO ***ONPOINT PHYSICAL THERAPY, INC.*** ALL INSURANCE BENEFITS, INCLUDING, BUT NOT LIMITED TO: HEALTH INSURANCE BENEFITS, AUTO INSURANCE BENEFITS, PRIVATE INSURANCE, AND ANY THIRD-PARTY INSURANCE TO THE EXTENT NECESSARY TO PAY ***ONPOINT PHYSICAL THERAPY, INC.*** FOR THE MEDICAL CARE AND TREATMENT IT PROVIDES THE PATIENT. A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I ALSO AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO ***ONPOINT PHYSICAL THERAPY, INC.***FOR ITS USE IN PROVIDING MEDICAL CARE AND TREATMENT TO THE PATIENT.

_____ _____
PATIENT / PARENT / GUARDIAN SIGNATURE DATE

AGREEMENT TO PAY FOR MEDICAL CARE AND SERVICES

ONPOINT PHYSICAL THERAPY, INC. MAY SUBMIT A BILL TO AN INSURANCE CARRIER AS A COURTESY TO PATIENT /PARENT/GUARDIAN/ RESPONSIBLE PARTY. I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE ENTIRE BELL OF ***ONPOINT PHYSICAL THERAPY, INC.***WHEN THE SERVICES ARE RENDERED. ARRANGEMENTS FOR PAYMENT OF OUTSANDING INVOICES SHOULD BE MADE TODAY. I AGREE THAT IF AN INSURANCE CARRIER DOES NOT PAY ***ONPOINT PHYSICAL THERAPY, INC'S*** STATEMNTS WITHIN 60 DAYS, I WILL PAY THE FULL BALANCE DIRECTLY TO ***ONPOINT PHYSICAL THERAPY, INC.*** I AGREE THAT IF AN INSURANCE CARRIER REQUESTS A REFUND OF PAYMENTS MADE, I WILL MAKE SUCH REFUNDS OR WILL ASSERT APPROPRIAT DEFENSES AS TO WHY A FEFUND IS NOT DUE. IN THE EVENT THAT AN INSURANCE CARRIER DOES NOT ***ONPOINT PHYSICAL THERAPY, INC'S*** FULL STATEMENTFOR ALL SERVICES PROVIDED, I AGREE TO PAY ANY DIFFERENCE NOT PAID BY SUCH INSURANCE CARRIER. IF AND INSURANCE CARIER PAYS ME DIRECTLY I WILL REMIT SUCH PAYMENTS TO ***ONPOINT PHYSICAL THERAPY, INC.,*** PURSUANT TO THE ASSIGNMENT MADE ABOVE. IF I CLAIM BENEFITS UNDER THE WORKERS' COMEPENSATION ACT AND SUCH BENEFITS ARE DENIED, I AGREETO PAY THE FULL AMOUNT BILLED BY ***ONPOINT PHYSICAL THERAPY, INC.*** IF ***ONPOINT PHYSICAL THERAPY, INC.*** IS NOT PAID WITHIN THE TERMS DESCRIBED HEREIN AND IT PURSUES A LAWSUIT AGAINST ME OR HIRES A COLLECTION AGENCY TO COLLET THE AMOUNTS DUE, I AGREE TO PAY ***ONPOINT PHYSICAL THERAPY, INC'S*** COURT COSTS, COLLECTION AGENCY FEES, AND REASONABLE ATTORNEY FEES.

ESTIMATED INSURNACE BENEFITS

ESTIMATED PATIENT PAYMENT PER VISIT/ CO-PAY _____

ARRANGEMENT FOR PAYMENT OF PATIENT'S SHARE _____

ATTENTION: WE PROVIDE AS A COURTESY TO OUR PATIENCE ESTIMATED INFORMATION. THIS INFORMATION IS ONLY ESTIMATED AT THE TIME CONTACT IS MADE WITH AN INSURANCE COMPANY. THIS DOES NOT RELEASE THE REPSONIBLE PARTY FROM LIABILITY AS PROVIDED ABOVE.

I HAVE READ THE ABOVE INFORMATION AND/OR IT HAS BEEN FULLY EXPLAINED TO ME. ***I, THEREFORE UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.***

_____ _____
PATIENT / PARENT / GUARDIAN SIGNATURE DATE

Medical Information Release Form

In order for us to be able to communicate with various persons regarding your medical file under applicable state and federal law, we need to obtain a hand signed Medical Information Release Form ("MIRF") from you.
I, _____ hereby grant permission to Onpoint Physical Therapy to discuss any and all medical related information with my medical practitioner, hospital, nursing facility, insurance company, attorney or any other agency that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein for the purpose of Onpoint Physical Therapy negotiating medical bills/payment on my behalf:
(Please check all that apply):

_____ Referring physician
_____ Spouse
_____ Parent
_____ Child
_____ Insurance Company
_____ Patient Attorney
_____ Other (please specify) _____

In the event that Onpoint Physical Therapy needs to reach you, please check which of the following situations are appropriate:

_____ Message left on home phone
_____ Message left on cell phone
_____ Message left at work phone
_____ Mail sent to home address
_____ Other (please specify) _____

I also **understand that:**

- I may revoke this medical information release at any time, in writing, but the release shall remain valid until revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include medical records of treatment for physical and/or emotional illness, except psychotherapy notes, including treatment of alcohol or drug abuse.
- Onpoint Physical Therapy will maintain the privacy of any information obtained and will not disclose such information to any other person or entity except as necessary to effectuate service or by express written permission by me.
- A copy of this form, including a facsimile, may be used in place of the original.

I acknowledge that I have read and understand this Medical Information Release Authorization. Further, I authorize the disclosure of my protected health information in accordance with the terms in this Authorization.

Patient Signature: _____ Date: _____