ADMISSION FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____State: _____ Zip: _____

Home Ph#: _____Work Ph#: _____

Email Address:_____

Employer Name: _____

Employer Address: _____

City: _____State: _____ Zip: _____

Date Injured: _____ _

SS#: _____Marital Status: S M D W O

Date of Birth: _____ Sex: M F

Workers Comp: Y N

Auto Accident Y N If yes, what State? _____ _

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ____**SELF**

Insured (Responsible) Party Name:_____

Address: _____

City: _____State: _____ Zip: _____

Home Ph#: _____Work Ph#:_____

Relationship to Patient: _____ _

Date of Birth: _____ SS#: _____ _

PHYSICIAN INFORMATION

Referring MD: _____ Phone _____ Primary Care MD: _____ Return to MD: _____ _

INSURANCE INFORMATION

If you are being seen for an injury related to workers' compensation or an automobile accident, please give us the name of your workers' compensation /automobile carrier instead of your primary personal medical insurance carrier.

Primary Insurance: _____ _ Phone:_____

Group #: _____Subscriber/SS#: _____

Pt. relation to insured: Self Spouse Child Other

Do you have Secondary Insurance? Y N Name:_____

Adjuster: _____Claim #: _____ _____

Is your case in litigation? Y N Attorney's Name:_____

How did you hear about Denver Physical Therapy, P.C.? *(check all that apply)*

Friend/Relative? Who?_____Physician: _____Insurance: _____

Yellow Pages: _____Website: _____Other: _____

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that **in** consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to Denver Physical Therapy, P.C., **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not *covered* by this assignment.

I understand that upon discharge I may request, **in** writing, a copy of my records.

I *have* read, understand and signed the Denver Physical Therapy, P.C. Financial Policy on the back of this page.

Signed: _____
Insured and/or Responsible Party

Dated: _____

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, **in** the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Denver Physical Therapy, P.C. I also understand that Denver Physical Therapy, P.C. may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed: _____
Insured and/or Responsible Party

Dated: _____ _

DENVER PHYSICAL THERAPY

ADMISSION FORM

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

All patients must complete our *Information and Insurance Form* before seeing the therapist.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so, on a bi-weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and DPT. It is ultimately your responsibility to see that your physical therapy bill is paid in full. Agreements with insurance companies vary greatly and it is your responsibility to know what your insurance covers and what portion you are responsible for. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying DPT within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5 will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive payment made out to both DPT and you, please endorse the check and forward to us.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) accompanying a minor are responsible for full payment of the minor's treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid by cash or check at the time of service.

MISSED APPOINTMENTS

Because we commonly have a waiting list, unless cancelled at least 8 hours in advance, our policy is to charge for missed appointments. The charge is $25.00 for the first missed appointment and $50.00 for each subsequent missed appointment. Insurance does not pay this charge. You are responsible. Please help us serve you better by keeping scheduled appointments, or call us to cancel, in a timely manner to allow another patient to have your scheduled time.

I have read the *Financial Policy.* I understand and agree to this *Financial Policy.*

HIPAA

I acknowledge the receipt of Denver Physical Therapy's *HIPAA NOTICE OF PRIVACY PRACTICES.*

Signed: _____ Dated: _____

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

__Yes __No If Yes, person's name: _____ _Relationship:_____

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke? ☐ Yes ☐ No**
Sex: ☐ Male ☐ Female If female, are you currently pregnant? ☐ **No** ☐ **Yes If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other: _____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____

Recent flare-up? ☐ No ☐ Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach): _____

How did your injury/symptoms occur? _____

_____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?
☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind? _____

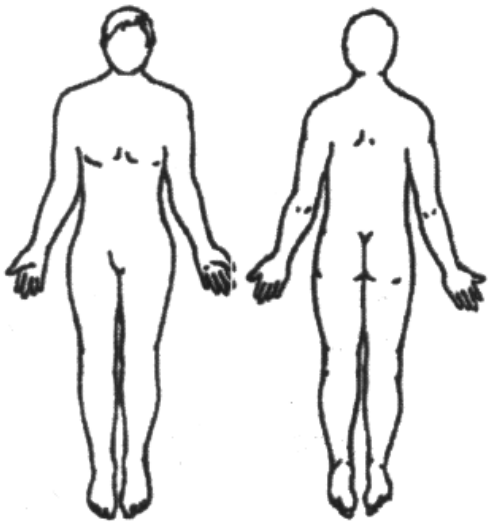
☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

- ☐ Physical therapy If yes, when? ___/___/___to ___/___/__
  What was done? _____
- ☐ Chiropractor If yes, when? ___/___/___to ___/___/___
  What was done? _____
- ☐ Medications: _____
- ☐ X-ray _____ ☐ MRI _____
- ☐ CT scan _____ ☐ Other: _____
- ☐ Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain ***III*** = Numbness



Comments: _____

_____

_____

Work Information

Who is your employer? _____

What is your job title/responsibilities? _____

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week _____

☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? ☐ No ☐ Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: _____

- Lift/carry: ☐ ≤ 20 lbs. rarely to occasionally (**low demand**)
  ☐ > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)
  Where to where _____ to _____.
- Repetitive motions related to condition: ☐ Occasional 1-33% (**low demand**)
  ☐ Frequent to Constant 34-100% (**mod-high demand**)
- Static positions related to condition (**mod-high**): ☐ Sit ☐ Stand ☐ Crouch
  ☐ Kneel ☐ Overhead work ☐ _____
- Leisure Activities: ☐ None/minimally impact condition **(low demand)**
  ☐ Moderate-high intensity, competitive **(mod-high demand)**

Overall functional demand (work/ADL/leisure) ☐ Low Demand ☐ Moderate-High Demand

Comments: _____

Additional Comments: _____

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

Drinking or Eating	Yes	No	Balancing on both feet	Yes	No
Sleeping Through the Night	Yes	No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	Ye	No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	Yes	No	Lifting	Yes	No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	Yes	No	Carrying	Yes	No
Getting in/out of: chairs, bed, car or bath/shower	Yes	No	Bending, Kneeling Squatting	Yes	No
Reaching: overhead, behind back, downward for forward	Yes	No	Driving a vehicle or ability to use gas/brake pedals	Yes	No
Gripping, Holding tools or Opening Jars	Yes	No	Caring for child or adult	Yes	No
Picking up Small Objects	Yes	No	Housework / Yard work	Yes	No
Sitting	Yes	No	Recreational Activities	Yes	No
Standing	Yes	No	Have you fallen more than 1 time in the past year	Yes	No
Job Related Activities	Yes	No	Have you fallen and hurt yourself in the past year	Yes	No

Other:

DENVER PHYSICAL THERAPY

CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)
LIST ALL OVER-THE -COUNTER MEDICATIONS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)
LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)