THE FIT INSTITUTE
PHYSICAL THERAPY | SPORTS PERFORMANCE

PHYSICAL THERAPY INTAKE FORM

Name: _____ DOB: _____ Age:_____

Home Address: _____ City: _____ State/Zip: _____

Email Address:
_____

Home Phone Number: _____ Mobile Number: _____

Occupation: _____ Work Phone:_____

Emergency Contact/Relationship:_____

Phone Number:_____

How did you hear about us? _____

What did you Google?_____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Phone: _____Fax: _____

Address: _____ City: _____ State/Zip: _____

INSURANCE INFORMATION

Insurance Provider: _____ ID Number: _____ Group Number: _____

Policyholder: _____ **DOB**: _____ Phone: _____

Policyholder's Address: _____
City: _____ State:_____ Zip:_____

SECONDARY INSURANCE INFORMATION

Insurance Provider: _____ ID Number: _____ Group Number: _____

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CURRENT COMPLAINT

Current Complaint:
_____

When did you symptoms start: _____

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you fallen in the last year? _____

Current symptoms are: Getting Better Worse No Different

Current Symptoms : Come and Go Constant Constant But Change With Activity

Have you received treatment for this condition? YES NO

What type of medical care? _____

Imaging: MRI Xray CT Scan

Are you currently working? Full Duty Light Duty Not Working- Date of Last Day:_____

Job Demand: Light Medium Heavy

Goals for Physical Therapy : _____

_____

MEDICAL HISTORY

Please check the following:

Shortness of breath Dizziness/Nausea Instability Fatigue

Weakness Numbness/Tingling Weight Loss/gain Night Pains

Change in bowel/bladder Headaches Fever/Chills

Please list any past medical history, surgeries, and illnesses that may affect our therapy.

_____

_____

Will you or your child require special/specific accommodations during treatment or when learning new exercises?If so, please list the needed accommodations:_____

_____

Please list any medications:_____

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HIPAA AUTHORIZATION FORM

I,_____, hereby authorize The FIT Institute and its employees, to access and/or release my personal health information obtained by examination, evaluation or treatment provided by The FIT Institute (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for communication regarding my condition in compliance with HIPAA regulations. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

Consent to Treat - I consent to and authorize my physical therapist to provide hands on examination, evaluation, assessment and treatment necessary to resolve my health condition. I understand methods of treatment may entail instrument-assisted soft tissue mobilization, dry needling and other manual therapy techniques.

Billing Policy and Contract - I acknowledge that I have discussed and agree to my physical therapy billing policy and contract. I acknowledge that I am financially responsible for the entirety of my physical therapy bill.

Cancellation Policy- I agree to provide 24 hours notice of cancellation to provide the therapist sufficient time to make accommodations to schedule. Failure to provide notice within this time frame will result in a ***Patients' Responsibility Late Cancel Fee of $100.00***

Collections Policy: If you incur a balance under any and all circumstances > 90 days, we will email you a billing statement to the email address you provided above. You will have seven days from that email to pay, otherwise we will charge the credit card you have on file. Any Cancellation Fee accrued throughout your plan of care will also be included in the sum sent out to our Collections Agency.

** If your account is sent to collections, it will incur a 25% processing fee. **

PHOTO AND VIDEO RELEASE

I hereby grant The FIT Institute permission to use photographs, video, or other digital media to evaluate and treat my condition. I understand and agree that all photos will become the property of TFI and will not be returned. I understand the photos may be used in research, social media advertising and/or projects to demonstrate therapeutic interventions. I hereby irrevocably authorize TFI to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I understand that I have a right to revoke this authorization by providing written notice to The FIT Institute. However, this authorization may not be revoked if The FIT Institute, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Name:_____

Signature:_____

Date:_____

Parent/Guardian Signature:_____