Print

Phone: (530) 541-7133
Fax: (530) 541-7132

2877 Lake Tahoe Blvd, Suite D
South Lake Tahoe, CA 96150

Patient Intake Form

Date: / /

PATIENT INFORMATION - To be filled out by patient				
First Name:		**Last Name:**		M.I.:
Address:		City:	State:	Zip:
D.O.B.: / /	Age:	Male ☐ Female ☐	SS: - -	
Home Phone #:	Mobile Phone #:		Work Phone #:	
Email Address:				
Employer:		Occupation:		
Blood Pressure (recent reading if known or leave blank):				
Height: feet inches	Weight: pounds	BMI (office use only):		

EMERGENCY CONTACT - To be filled out by patient	
Name:	Relationship to Patient:
Home Phone #:	Alternate Phone #:

REFERRING INFORMATION - To be filled out by patient	
Referred by:	Date of Injury: / /
First Medical Visit:	Date of Surgery: / /

INSURANCE INFORMATION - To be filled out by patient OR provide insurance card at time of visit			
Name of Primary Insurance:		**Insurance Phone #:**	
Subscriber's Name:		**D.O.B.:** / /	
ID#:	**Group Policy #:**		
Patient Relation to Insured: Self ☐	Spouse ☐	Child ☐	Other ☐
Name of Secondary Insurance:			
Subscriber's Name:		D.O.B.: / /	
ID#:	Group Policy #:	Relation: Self ☐ Spouse ☐	Child ☐ Other ☐

Phone: (530) 541-7133
Fax: (530) 541-7132

2877 Lake Tahoe Blvd, Suite D
South Lake Tahoe, CA 96150

Pain Diagram and Rating

1. Please mark the **severity of pain** you are currently experiencing on a scale from 0 to 10.

Current Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

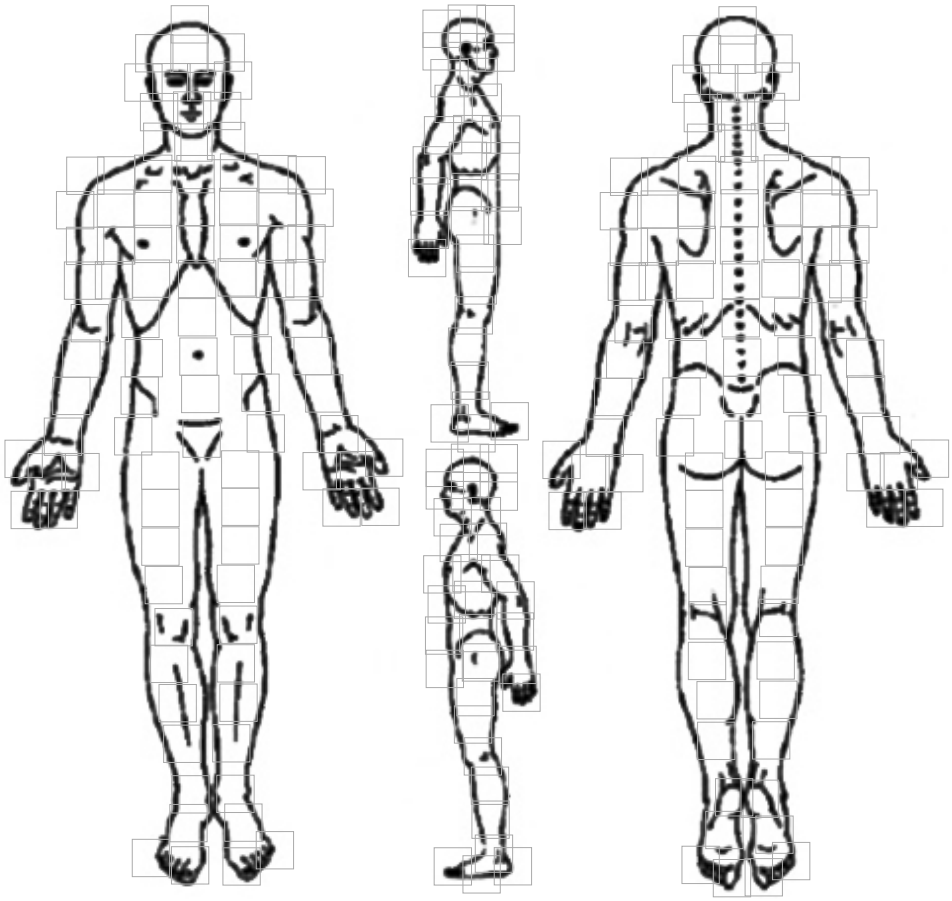
Average Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

2. Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

☐ Aching	☐ Dull	☐ Shooting	☐ Swelling
☐ Burning	☐ Numbness	☐ Stabbing	☐ Throbbing
☐ Cramps	☐ Sharp	☐ Stiffness	☐ Tingling

☐ Other, please describe: _____

3. Please mark on the diagram the **location of pain** as accurately as possible.



Phone: (530) 541-7133
Fax: (530) 541-7132

2877 Lake Tahoe Blvd, Suite D
South Lake Tahoe, CA 96150

Medical Screening

Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Diabetes	☐	☐	Spinal Disorders	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Nervous Disorders	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Kidney Problems	☐	☐	Seizures	☐	☐
Heart Disease	☐	☐	Allergies/Asthma	☐	☐	Rheumatoid Arthritis	☐	☐
Pacemaker	☐	☐	Sensitivity to Heat/Ice	☐	☐	Osteoarthritis	☐	☐
Neck/Back Pain	☐	☐	Hernia	☐	☐	Osteoporosis	☐	☐
Headaches	☐	☐	Metal Implants	☐	☐	Fibromyalgia	☐	☐

Please list all current medications: _____

_____

Financial Policy

We are committed to providing you with the best care possible. We will be pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

REGARDING INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to that contract in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “allowable” charges, etc., other than to supply factual information as necessary.

I authorize my insurance company to pay Mind Body Physical Therapy directly for my care. I understand that I am responsible for all charges not covered by my insurance. Deductibles and co-payment amounts are required at the time of service, unless other arrangements have been authorized by the office manager. If payment is not received from the insurance company within 45 days, it becomes the patient’s responsibility and there will be a 1.5% per month interest charge on all remaining balances. You are responsible for timely payments of your account. Should this account become delinquent, you will be responsible for all reasonable costs of collection.

WORKER’S COMPENSATION

We will bill your employer’s industrial insurance. If your injury is determined to NOT be work related, you will be responsible for the balance due in 30 days, or we reserve the right to bill any private insurance you have.

LIENS

Upon verification by your attorney, we will accept your lien. The patient understands that we will be paid the full balance of our bill once the case settles.

Phone: (530) 541-7133
Fax: (530) 541-7132

2877 Lake Tahoe Blvd, Suite D
South Lake Tahoe, CA 96150

Scheduling Policy

Please schedule each appointment with us; we will not automatically do this. We suggest you schedule appointments in advance to obtain optimum times. Cancellation requires 24 hours notice. If you are unable or feel you should not attend an appointment, please discuss your options with us. **You will be charged $25 if you miss an appointment without adequate notice.** You, not your insurance carrier, are responsible and will be billed for this.

Patient Information Consent Policy

I authorize Mind Body Physical Therapy to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Mind Body Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

Treatment Consent Policy

I authorize Mind Body Physical Therapy to provide any and all treatment which they, in their professional judgment, feel will help me improve. I understand that they cannot guarantee success and that some forms of treatment are painful. I understand that most therapy requires my participation and that my adherence to my home program is necessary for success.

I acknowledge that I have read and understand ALL of the above policies and that I have completed the requested information to the best of my ability.

Patient's Name _____ **Patient's Signature** _____ **Date** _____
PLEASE PRINT

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated

Patient's Name _____ **Representative's Name** _____
PLEASE PRINT PLEASE PRINT

Representative's Signature _____ **Relationship/Authority to Patient** _____

Date Signed _____ **Witness** _____
