HaydenLake
PHYSICAL THERAPY & AQUATICS

Patient Intake Paperwork Checklist

Thank you for choosing Hayden Lake Physical Therapy and Aquatics for your physical therapy needs. Please read and fill out the following documents and bring them to your first appointment.

- ☐ Patient Information Sheet
- ☐ Financial Arrangements and Insurance Coverage
- ☐ Medical History Form
- ☐ Now Show Policy Form
- ☐ Notice of Privacy Practices Acknowledgement Form

If you have any questions, please contact us and we will be happy to assist you.

Hayden

1088 W. Prairie Ave.
Coeur d'Alene, ID 83815

P 208.772.6609
F 208.762.4440

Coeur d Alene

1450 Northwest Boulevard #106
Coeur d'Alene, ID 83814

P 208.667.6264
F 208.664.4313

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Legal Name _____ Nickname _____ Male _____ Female _____
Home Phone _____ Cell Phone _____
Street Address / PO Box _____
City, State _____ Zip _____
Date of Birth _____ Social Security Number _____

Would you like appointment reminders? Please choose only one option:
Email _____ Text _____ Voice Call to Cell _____ Voice Call to Home _____
Email address for appointment reminders (please print clearly) _____
May we leave a detailed message at: Home _____ Cell Phone _____ Work _____ None _____
Employer Name and Address _____
Employer Phone_____ Spouse's Employer _____
Spouse's Name_____ Spouse's Phone _____
Parent's Name (if patient is a minor) _____
Who is financially responsible for your bill? _____
Nearest relative not living with you _____
Whom may we contact in case of emergency? _____ Phone _____
Physician _____
Have you had any prior Physical Therapy this calendar year? Yes _____ No _____
Are you having or have you had in-home therapy (P.T. or O.T) within the last month? Yes _____ (Last date _____) No _____

Insurance Information (If the patient is not the insurance subscriber, please complete the subscriber's name and date of birth.) Medicare _____ Medicaid _____ Private Ins. _____ Worker's Comp _____ MVA _____ Cash _____
Name of Insurance Company _____
Insurance Company Address _____
Phone_____ ID/Claim Number _____ Group Number _____
Subscriber_____ Social Security Number _____ Date of Birth _____
Date of Injury_____ Briefly Explain _____

Release of Information/Treatment Consent

I do hereby consent to Physical Therapy treatment for myself or my child (**Patient's Name**) _____.
I authorize you to furnish my doctor and/or insurance company with pertinent information regarding my treatment.

Insurance Authorization

I authorize the release of any information necessary to process this claim and hereby instruct and direct my insurance company to pay Hayden Lake Physical Therapy and Aquatics for medical services.

I understand and agree (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient Signature_____ Date_____
Parent's Signature (if patient is a minor)_____ Date_____
Parent's Social Security Number_____ Parent's Work Phone _____

Please read financial agreement and cancellation information on back.

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Financial Arrangements and Your Insurance Coverage

We are committed to provide the best possible care to you. In order to achieve this goal we need your assistance and understanding of some of our policies:

***Payment for service is due at the services are rendered unless payment arrangements have been approved in advance by our staff.

Insurance Coverage:

***If you have medical insurance we will help you receive your maximum allowable benefits. We will help you process your insurance claim form as a courtesy to you.

1. We accept assignment on certain insurance plans in which case the patient portion of the bill remains due at time of service.
2. We accept cash, checks, and credit cards.
3. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment plan and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

If temporary financial problems affect timely payment of your account, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Cancellation and No-Show Policy

To obtain maximum benefit from your therapy session, it is important that you attend your physical therapy sessions regularly. If for some reason you cannot attend therapy regularly, please speak with your therapist. After **three cancellations or no shows**, you will be re-evaluated by your therapist to determine your need for continued therapy.

When you schedule an appointment with us, we reserve the time slot just for you. If you are unable to attend one of your appointments, we ask that you call and give us **four hours** notice prior to your appointment time. **No shows and cancellations made less than 24 hours prior to your appointment time will be charges a $15.00 fee. Your insurance does not cover this fee.**

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Medical History Form

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

Please circle your pain level...

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Please list your current medications (i.e. prescription, over the counter, herbals, vitamins, dietary supplements):

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list all prior surgeries, injuries, or medical procedures and the date(s) performed (if known):

Surgery/Injury/Procedure	Date	Surgery/Injury/Procedure	Date

Prior to motor vehicle accident (MVA)? YES NO

Prior to motor vehicle accident (MVA)? YES NO

Please list all **prior** and **current health issues:**

Alzheimer Disease
Parkinson Disease
Deep Brain Stimulator
High Blood Pressure
Heart Disease
Pacemaker
CVA (Stroke)
Traumatic Brain Injury

Bladder / Bowel Dysfunction
Numbness / Tingling
COPD / Emphysema
Current Infection
Diabetes Type 1 / Type 2
Fibromyalgia
Fracture: _____
Cancer: _____

Huntington Disease
Immunosuppression
Lupus
Muscular Dystrophy
Obesity
Osteoarthritis
Osteoporosis / Osteopenia
Rhuematoid Arthritis (RA)

Allergies: _____
Psychological:
Depression / Anxiety /
Bipolar / PTSD /
ADHD / Schizophrenia /
ODD / Other: _____
Falls last year: _____

If you have a condition that requires **further detail** or have any **conditions not listed above,** please describe:

_____
_____
_____

Date Updated/Initials: _____ _____ _____ _____

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No Show Policy

If you are unable to make your scheduled appointment, please call at least **four hours** prior to the appointment. We will attempt to call you if we do not see you within 15 minutes of your scheduled time. You will be charged a $15 fee for each no-show. This fee is not covered by your insurance. After three no-show or three consecutive cancellations, your Physical Therapist reserves the right to discharge you from our clinic.

Signature: _____ Date: _____

Medicare Benefits

I request payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished me by that Physician/Supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accounting Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment. Follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Parent/Guardian Name if Minor: _____ Relation: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

Office Use Only

I attempted to obtain the Patient's Signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Patient Name: _____

Reason: _____