New Patient Intake Form

Please complete ALL sections

1) Patient: Full Legal Name or as on Insurance Card

_____

Name: Last First Middle Sr.Jr. Nickname

_____

Mailing Address: Street APT # City State Zip

Home Phone: (____) _____ - _____ **Mobile Phone: (_____) _____ - _____**

Date of Birth: _____/_____/_____ **Social Security Number: _____-_____-_____**

Email Address: _____ (We will *NOT* share this. By entering it, you agree to receive periodic emails from RPTC about coupons, upcoming seminars, or health tips).

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family ☐ Internet ☐ Google ☐ Facebook ☐ Sign

What specifically brought you to RPTC? Why did you choose us? _____

_____

If doctor, friend, or family, please give us their name so we may thank them, (friend or family will also receive a $10 gift certificate for use at RPTC): _____

Referring person's address and/or phone number: _____

2) Medical History

Height:_____ Weight:_____ Occupation: _____

List any significant medical history: (diseases, conditions, allergies, surgeries, cardiac, pulmonary/circulation issues:

_____

_____

Prior to this injury, how many days a week did you exercise? _____
How many days a week are you currently exercising? _____
Have you been previously or currently being seen for this issue? ○ **Y** ○ **N**
If yes, when/where? _____
Does your pain wake you up? ○ **Y** ○ **N**

Please indicate your CURRENT pain level. 0 is No Pain - 10 Being Most Severe:

Please indicate your pain level when it is at its WORST. 0 is No Pain - 10 Being Most Severe:

Please indicate your pain level when it hurts the LEAST. 0 is No Pain - 10 Being Most Severe:

Please select *ANY* areas of your body that you are *NOT* comfortable with the therapist touching/ massaging: ☐ Back ☐ Legs ☐ Buttocks ☐ Hands ☐ Arms ☐ Abdomen ☐ Pecs/Upper Chest ☐ Head ☐ Neck ☐ Face

Do you have any infectious diseases? ◯ Y ◯ N If yes, please list: _____

Do you have trouble falling asleep? ◯ Y ◯ N

How many times a night do you get up to use the bathroom? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5+

Do you smoke cigarettes? ◯ Y ◯ N ◯ Quit Do you have a pacemaker? ◯ Y ◯ N

Females ONLY – Are you pregnant? ◯ Y ◯ N If yes, how many weeks? _____ What is your due date: _____

3) Condition to be treated in Physical Therapy: _____

Date Condition Began? _____/_____/_____

Is it related to an automobile accident? ◯ Y ◯ N Date of Accident: _____/_____/_____

Is it a work related accident? ◯ Y ◯ N Date of Accident:_____/_____/_____

Did this condition result in surgery? ◯ Y ◯ N Date of Surgery: _____/_____/_____

Have you had PT for this condition? ◯ Y ◯ N If yes, where? _____

Have you had Chiropractic services for this condition? ◯ Y ◯ N If yes, where? _____

MEDICARE PATIENTS ONLY

Are you receiving *ANY* other PT/OT services? ◯ Y ◯ N If yes, from who? _____

4) Patient's Doctor: Please list the doctor who referred you to therapy

_____

Last Name First Name MD,DO,NP,PA, Other Office Phone

5) Auto or Work Accident Claims

Who will be paying the claim? _____Your personal car insurance? _____ Liability Claim?

Insurance Company: _____ Claim_____

Adjustor's Name: _____PH: (____) _____-_____ Fax: (_____) _____-_____

Claim Mailing Address: _____

Street City State Zip

If pursuing Litigation:

Name of Law Firm: _____ Name of Attorney: _____

Address of Law Firm: _____

Street City State Zip

Phone and Fax # of Law Firm: PH: (____)_____-_____ FAX: (_____) _____-_____

Sign A, B, and C

A) I understand and agree to The Ruidoso Physical Therapy Clinic, Inc. terms of service stating that we DO NOT accept a "Letter of Protection/Lien", we WILL NOT wait for subrogation, ALL payments are due AT THE TIME OF SERVICE. You will be given a receipt and financial statement to submit for reimbursement.

Patient Signature: _____

B) I understand that if I am using my personal car insurance I must assign payment benefits to The Ruidoso Physical Therapy Clinic, Inc. and be prepared to pay should I exhaust the medical funds.

Patient Signature: _____

C) If at any time during therapy I do retain an attorney, I will inform The Ruidoso Physical Therapy Clinic, Inc. IMMEDIATELY. Furthermore, I understand from the date of retention ALL PAYMENTS WILL BE DUE AT THE TIME OF SERVICE.

Patient Signature: _____

6) Emergency Contact Information

Name: _____ Phone # (_____) _____-_____

Relationship to patient: _____ Alternate Phone, if available: (_____) _____-_____

7) Medications: This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Medication/Drug Name	Dosage	Number of time per day

8) Payment and Consent Authorization: Initial in acknowledgement of understanding for all 5 statements.

_____ CONSENT TO TREAT

I request and authorize the staff of The Ruidoso Physical Therapy Clinic, Inc. to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my doctor or physical therapist may deem reasonable and necessary.

_____ ASSIGNMENT OF INSURANCE BENEFITS

I authorize that the payment of my insurance benefits be made directly to The Ruidoso Physical Therapy Clinic, Inc. for all services delivered; if I am paid directly I will promptly pay the RPTC all monies paid to me.

_____ GUARANTEE OF PAYMENT

I understand that ALL payments designated as "the patient's responsibility" such as co-insurance, deductibles, and co-payments are due and payable at the time of service or receipt of statement. I guarantee I will pay the amount deemed "my responsibility" by my insurer within 30 days of statement date or a *$10.00 late charge will be added to each monthly statement.*

_____ CERTIFICATE OF INFORMATION

I certify that the information I have provided The Ruidoso Physical Therapy Clinic, Inc. for payment including, but not limited to, related accidents, illnesses, or other insurers is accurate and truthful.

_____ **LATE CANCELLATION/NO SHOW POLICY**

I understand that I am required to notify The Ruidoso Physical Therapy Clinic, Inc. in the event that I need to cancel any scheduled appointments. This notification must be given no later than 24 hours in advance. If I fail to contact the office and DO NOT show up for my appointment; this will count as a NO SHOW. The office staff or answering service is available 24 hours per day and IF I FAIL TO NOTIFY THIS OFFICE OF MY CANCELLATION.

A $50.00 NO SHOW FEE MAY BE ASSESSED. My insurance company cannot be billed for cancellations/no shows; therefore, I will be required to pay this fee on my next visit. My insurance company and my physician will be notified of my cancellation or no show. NOTE: two or more NO SHOWS will/can result in my no longer being able to be treated at The RPTC.

There will be a $35 charge for a returned check. There will be a $10 per month charge per month for any ouitsanding balance.

Credit Card to be used on file:

Credit Card Number:_____

Name on card:_____

Expiration:_____

CCV:_____

9) Signature **Date**

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for THE RUIDOSO PHYSICAL THERAPY CLINIC, INC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to THE RUIDOSO PHYSICAL THERAPY CLINIC, INC to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature