Waite Rehab & Wellness, LLC

PATIENT INFORMATION – PLEASE READ CAREFULLY AND COMPLETE IN FULL

Patient Name: _____ Today's Date: _____

Sex: _____ Age: _____ DOB: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: S M W D Social Security # _____

Patient Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Is the patient under Home-Health or Hospice Care? Yes / No - Alert front desk immediately if yes.

Primary Insurance Company: _____

Subscriber Name (if not patient): _____ DOB: _____
Relation to Patient: _____

Secondary Insurance Company: _____

Subscriber Name (if not patient): _____ DOB: _____
Relation to Patient: _____

When is your follow-up appointment with your referring doctor? _____

Type of Accident / Injury / Surgery / Work / Auto / Other: _____

Date of Accident / Injury / Surgery: _____

Have you received therapy from any other provider during this calendar year? Yes No

Outpatient Physical Therapy Intake Form

Name: _____ DOB: _____ Date: _____

Who referred you? _____

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? Y N Have you ever smoked? Y N If yes how often?: _____

Are you pregnant? Y N Do you have a pacemaker? Y N Allergies: _____

Current Medications: _____

_____

Previous Surgeries: _____

Previous Diagnoses (Circle all that apply)

AIDS/HIV	Anemia	Angina	Arteriosclerosis	Arthritis	Asthma	Blood clots
Cancer	Depression	Diabetes	Heart Disease	Epilepsy	High/low blood pressure	
Lung Issues	Pneumonia	Stroke	Urinary Infection	OA/RA	Other: _____	

If Yes, please elaborate: _____

In the past 3 months have you had or experienced?

Fever/chills/sweats? Y N Unexplained weight change (>10lbs)? Y N

Numbness or tingling? Y N Bowel/bladder incontinence? Y N

Unexplained Falls? Y N Difficulty sleeping due to pain? Y N

Chief Complaint? _____

Injury/Surgery Date: _____ Possible Cause: _____

Symptoms: _____

Imaging: ____ X-ray ____ MRI ____CT Other: _____

Previous Doctors seen for Complaint: _____

Previous Treatment for Complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They are Worst: _____

Pain Scale 0 - 10 (0 = no pain/10 = emergency room): Now _____ Best _____ Worst _____

Current Duration of Pain: ___ Intermittent ___ Constant ___ With Certain Motions

Is your pain getting better or worse? _____ Have you had this injury before? _____

Physical Therapy Evaluation and Treatment

I consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. Physical therapy is most effective if you participate according to the plan of treatment agreed upon with your therapist. If at any time you have questions or concerns, please talk with your therapist. Remember, we are here to provide you with the best care available in order to improve your quality of life through physical therapy.

Medical Insurance Authorization and Release

I authorize Waite Rehab & Wellness to correspond to my insurance company(s) as the provider of physical therapy services rendered at our facility. Waite Rehab & Wellness shall act as an agent in collection of payment from your insurance company(s), not limited to submission of medical records obtained at our facility as necessary for claim processing.

Patient Financial Responsibility

I accept full and complete financial responsibility for all medical services rendered to the registered patient and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make payments in accordance with the expressed/implied payment policy of Waite Rehab & Wellness, or in the event of default of my financial obligation to pay for services rendered, Waite Rehab & Wellness reserves the right to forward all fees for-services to an external collection agency.

All applicable co-payments, co-insurance and deductible amounts are due at the time of service.

Missed Appointment Policy

Appointments that are canceled less than 24 hours in advance of the appointment time are considered late-notice cancellations. Instances where the patient has not arrived and signed in within 10 minutes of the appointment time is considered a missed appointment. Late-notice cancellations and missed appointments will each result in a $30.00 fee.

By signing below, I have read and agree to the above and certify that the information I have provided to Waite Rehab & Wellness is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Print name: _____ Social Security # _____