Maximum Fitness

Physical Therapy & Sports Medicine

Intake Form

Patient Name: _____ DOB:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ E-Mail:_____

Emergency Contact: _____

Phone: _____ Relationship:_____

Referring MD/Facility: _____

Phone: _____ Fax:_____

Injury/Diagnosis: _____

Date of Injury/Surgery: _____

Date of Follow up Appointment: _____

Are you presently working? : _____

Height: _____ Weight:_____

Are you currently on any medications? : _____

If yes, what type and dosage of medications? : _____

_____

_____

Do you have any medical allergies? If yes please list them : _____

_____

Consent to treat and Authorization to release information

HIPAA AUTHORIZATION FORM

I hereby authorize Maximum Fitness Physical Therapy through its appropriate personnel to perform the evaluation ant treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize Maximum Fitness Physical Therapy to furnish the appropriate agencies for the purpose of billing, any information acquired during the course of my treatment. I am assigning my therapy benefits to Maximum Fitness Physical Therapy for the services in which I receive and authorize my insurance carrier to make payment to Maximum Fitness Physical Therapy on my behalf. Maximum Fitness Physical Therapy reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. . All records released require an administrative and copying fee paid to Maximum Fitness Physical Therapy before they are released, regardless of the requester. Maximum Fitness Physical Therapy in HIPAA compliant with regard to information sharing policies.

By signing this document, I acknowledge that I have read, and understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my State issued drivers license, State issued photo identification and or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct, and complete to the best of my knowledge. I agree to the financial terms stated above.

I hereby authorize the use or disclosure of my protected health information as described below:

1. Authorized persons to use and disclose protected health information
2. The information that may be disclosed, including the following: Medical records, all past, present and future periods of health care information and any and all treatment records.
3. The purpose of this use or disclosure is to allow proper treatment from a number of doctors
4. Acknowledgement

   I understand that the information used or disclosed under this authorization form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

Print Name: _____

Signature: _____

Date: _____

General Information
Health Questionaire

Please put an "X" in box for each symptom

Symptom	Yes	No	Symptom	Yes	No
Smoking			Night Sweats/Pain		
Diabetes			Pregnant		
Heart Condition			Sexual Dysfunction		
High Blood Pressure			Bladder Problems		
Chest Pain			Groin Numbness		
Stroke			Arthritis		
Kidney Condition			Osteoporosis		
Blood Clot/ DVT			Psychological Cond.		
Metal Implants			Seizures		
Pacemaker			Dizziness/Faintness		
Difficulty Breathing			Ringing in Ears		
Weight Loss			Infection		
Double Vision			Fever/Nausea		

Current Episode of Care & Pain Index

What is your main goal for PT? : _____

Have you received PT previously for this same condition? : _____

Current pain level on a scale of 1- 10: _____

What time of day do you feel the best? : _____

What time of day do you feel the Worst : _____

How are you currently able to sleep due to your symptoms : _____

What position or activities make your symptoms better? : _____

What position or activities make your symptoms worse? : _____

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Consent to Communicate

I hereby authorize Maximum Fitness Physical Therapy through its appropriate personnel to communicate with _____ who is my Doctor, and _____ who is my insurance provider regarding my health, billing and payment for services rendered on my behalf. Additionally, I hereby authorize Maximum Fitness Physical Therapy through its appropriate personnel to communicate with _____ who is my _____. I acknowledge that if any other person calls on my behalf and I did not list them on this form that they will not be able to access any of my information.

Print Name: _____

Signature: _____

Date: _____

Cancellation and No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. We request that you please give a 24 hour notice of a change to your appointment.

If an appointment is not cancelled at least 24 hours in advance you may be charged a nominal fee of twenty-five dollars ($25); this will not be covered by your insurance company.

Thank you for your understanding.