New Patient Intake/ Verification Form

PATIENT INFORMATION (To be completed by Patient)

Today's Date	**Initial Evaluation Date/Time:**	**Therapist:**	**Office:**
First Name:	**Last Name:**	**DOB:** / /	**Gender:** ❑ Male ❑ Female
Address:			
Phone: ( )	**Alt Phone:** ( )	**Email:**	
Diagnosis/ Body Part:	**Referring Physician:**	**Intake By:**	

How did you hear about us?:

❑ Doctor ❑ Insurance Plan ❑ Friend/ Family ❑ Returning Patient ❑ Google ❑ Website ❑ Other _____

INSURANCE INFORMATION (Office Use Only)

Primary Insurance:					
Address:			**Phone:**		
Subscriber (If different):			**DOB:** / /	**Relationship:**	
ID#			**Group #**		
Effective Date	**Term Date**	**Network Coverage?** ❑ In Network ❑ Out Network	**Out Area Coverage?** ❑ Yes ❑ No ❑ N/A	**Plan level?** ❑ HMO ❑ PPO ❑ POS	
Copay: $	**Coinsurance:** %	**Deductible Apply?** ❑ Yes ❑ No	**Deductible**	**Deductible Met**	**Deductible Left**
Max # Visits	**Visits Used**	**Are Visits combined with OT/ SLP?** ❑ Yes ❑ No		**Per** ❑ Condition ❑ Cal Year ❑ Plan Year	
Requirements? ❑ Referral/ Script ❑ Pre-Cert ❑ Auth		**Auth Info?**		**Out Pocket**	**Out Pocket Left**
Spoke to:	**Date:**	**Ref#**			

SECONDARY INSURANCE (Office Use Only)

Secondary Insurance:					
Address:			**Phone:**		
Subscriber (If different):			**DOB:** / /	**Relationship:**	
ID#			**Group #**		
Effective Date	**Term Date**	**Network Coverage?** ❑ In Network ❑ Out Network	**Out Area Coverage?** ❑ Yes ❑ No ❑ N/A	**Plan level?** ❑ HMO ❑ PPO ❑ POS	
Copay: $	**Coinsurance:** %	**Deductible Apply?** ❑ Yes ❑ No	**Deductible**	**Deductible Met**	**Deductible Left**
Max # Visits	**Visits Used**	**Are Visits combined with OT/ SLP?** ❑ Yes ❑ No		**Per** ❑ Condition ❑ Cal Year ❑ Plan Year	
Requirements? ❑ Referral/ Script ❑ Pre-Cert ❑ Auth		**Auth Info?**		**Out Pocket**	**Out Pocket**

Verified by:_____ **Date:** _____

TRUESPORTS
PHYSICAL THERAPY

Physical Therapy Medical History Questionnaire

Patient Name: _____ DOB: ____/____/____ Age: _____

Occupation: _____ Indicate the physical requirements of your job |---------- Sedentary ---------- Very physical|

Who referred you to us? _____ Primary Care Physician name: _____

What is your diagnosis / chief complaint? _____

When was the onset (date) of your problem? _____ Date of surgery? _____

What are your goals in coming to physical therapy? _____

Have you had PT for this condition before? ☐ Yes ☐ No

What treatment(s) have you had for this problem: _____

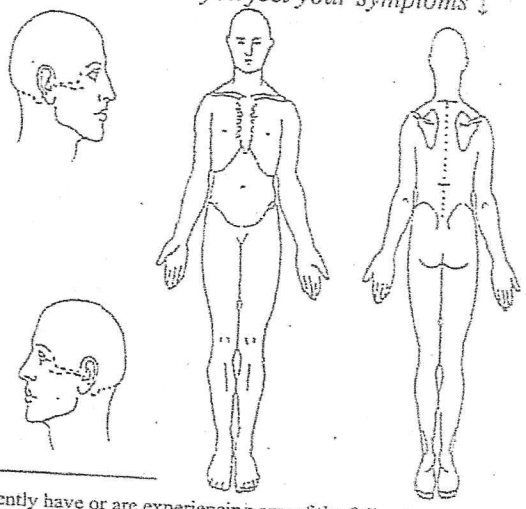
Have you had anything similar before? ☐ no ☐ yes, describe: _____

List any regular leisure / physical activities, exercise, sports, etc: _____

Please circle and list any medications you are currently taking:
High Blood Pressure Anti-inflammatory Pain Muscle Relaxant
☐ Other: _____

Please circle any diagnostic studies you have had for your current problem:
X-Ray MRI CT Scan EMG/NCV Other: _____

Please draw & describe on the diagrams where you feel your symptoms ↓



Please list any known allergies: _____

Please check if you have or had any of the following:

Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Kidney Disease/Stones	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Polio	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Osteoporosis/Osteopenia	☐ Yes ☐ No

Please check if you currently have or are experiencing any of the following:

Numbness/Tingling	☐ Yes ☐ No
Loss of skin sensation	☐ Yes ☐ No
Muscular Weakness	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No
Nausea/Vomiting	☐ Yes ☐ No
Fever/Chills	☐ Yes ☐ No
Unexplained Weight Loss	☐ Yes ☐ No
Bowel/Bladder Changes	☐ Yes ☐ No
Fatigue/Shortness of Breath	☐ Yes ☐ No
Difficulty sleeping	☐ Yes ☐ No
Females only:	
Pregnancy/Recent child birth	☐ Yes ☐ No
Urinary incontinence/OAB	☐ Yes ☐ No
Pelvic Pain	☐ Yes ☐ No

_____ _____
Patient signature Date

(Please use the back of this form for additional information you wish to communicate to your physical therapist.)

TRUESPORTS
PHYSICAL THERAPY

Patient Responsibility/ Financial Policy

Please read each policy and sign, acknowledging that you have received this notice and agree to the below policies.

Consent for Care & Treatment: I hereby agree and give my consent to True Sports Physical Therapy , LLC to provide outpatient physical therapy services considered reasonable and medically necessary in diagnosing and/or treating my physical condition.

Benefit Assignment/ Release of Information: I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and third party payers for services provided by True Sports Physical Therapy, LLC. I also authorize the release of any and all information necessary, including medical recoded, to secure payment for services.

Patient Responsibility: It is the patient's responsibility to provide current insurance card (s), photo ID, contact information, and referral/ prescription prior to treatment. Failure to do so will cause the patient to bear responsibility for all charges. Additionally, it is the patient's responsibility to inform us if they have been seen at another therapy clinic (Physical, Occupational, or Speech-Language Pathology).

Financial Policy: True Sports Physical Therapy LLC, does not accept responsibility for any incorrect information provided by you or your insurance carrier regarding your eligibility or benefits. The patient is financially responsible for all copays, coinsurance, deductibles, or "self pay" estimated amounts at the time services are rendered. If for any reason your insurance does not pay for the services provided, the patient shall assume full responsibility for the total amount owed. We reserve the right to not render service or schedule future appointments for account balances. You may receive paper and/or electronic billing statements for any outstanding balances not collected in the office. You may request a paper statement billing statements@mcsbilling.com Any outstanding balances not paid after three statements may be turned over to a debt collection agency.

No Show/ Cancellation Policy: If you are unable to keep your appointment, please provide 24 hour notice. We reserve the right to a charge a $50.00 fee for missed appointments without a compelling reason. Failure to cancel three consecutive appointments without adequate notice, may result in termination of the provider- patient relationship. We understand that unavoidable circumstances sometimes occur and you may not be able to cancel within 24 hours; fees in this instance may be waived at the discretion of management.

Payment Methods/ Credit Card Authorization: We accept Cash, Check, and Debit/ Credit Cards. Returned checks or declined transactions may result in a $40.00 service charge. Effective 8/1/2018, we require a credit card (not a debit card) on file as a guarantee of payment for any balance after insurance processing. Copays/ coinsurance/ deductibles, etc will always be collected at the time services are rendered. Our billing company Medical Claims Solutions (MCS) will email a billing statement and receipt for the transaction. A courtesy call will be provided before the card is charged for any balance greater than $350.00. Please be advised that stored credit card information is in compliance with all federal and consumer rules protecting and regulating the storage and use of this information (PCI SSC). My signature below authorizes True Sports Physical Therapy, LLC to charge my credit card for any patient responsibility If I wish to update/ my card, I will notify the staff and complete a separation authorization form.

Auto Accident/ Workers Comp: It is the patient's responsibility to us if their treatment is the results of an auto accident or employment injury. We do not bill Attorneys, PIP, or accept settlements. Any charges not covered by the Auto/ Workers Compensation carrier, will be billed to the patient. I hereby authorize payment directly to True Sports Physical Therapy, LLC for services rendered to me as described in the paper/ computer bill. This authority shall supersede all prior subsequent instructions to the third party payor by the undersigned or his/her legal representatives. Mail payments to True Sports Physical Therapy 3307 Timberfield Ln Baltimore, MD 21208

I have read the above information and certify that I understand and will abide by the above policies set forth by True Sports Physical Therapy, LLC.

_____ _____

Patient Name (please print) **Date**

_____

Patient Signature

TRUESPORTS
PHYSICAL THERAPY

Credit Card Authorization Form

Effective August 1, 2018 we require a credit card (not a debit card) to be on file for all patients. In our effort to be more "green", patients will no longer receive a billing statement in the mail. You may request a paper copy by emailing statements@mcsbilling.com. This policy authorizes True Sports Physical Therapy LLC, to charge the credit card listed below, for balances related to services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by True Sports Physical Therapy LLC. Copays/ deductibles/ coinsurance payments will still be collected in office on the date service are rendered.

Credit card payments will be processed by our billing company Medical Claims Solutions (MCS). MCS will email a billing statement and receipt. You will receive a courtesy call for any patient balance greater than $350.00. If your credit card account is closed or expired please notify us as soon as possible. Declined transactions without alternative payment will incur a $40.00 penalty.

Your insurance company will continue to send an Explanation of Benefits (EOB) that explains how much your insurance paid for therapy and how much you are responsible to pay. Our new policy will in no way compromise your ability to dispute a charge. Questions can be directed to MCS at 410-358-5530 option 3. Please be assured that the stored credit card information is in compliance with all federal and consumer rules protecting and regulating the storage and use of this information (PCI SSC).

Credit Card Information

☐ Amex ☐Visa ☐Mastercard ☐Discover

Cardholder Name: _____

Credit Card # _____

Expiration Date: _____/_____ **Security Code:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email : _____

Phone: _____ **Alt Phone:** _____

Signature: _____ **Date:** _____

TRUESPORTS
PHYSICAL THERAPY

Notice of Privacy Practices

This notices describes how medical information about your may be used and disclosed. We are required by law to protect the privacy of your health information. This document also explains how you can gain access to your medical information.

A. The general consent for release of medical records that you sign authorizes True Sports Physical Therapy, LLC to disclose the information in your medical record for treatment, payment, and health care operations.
   a. For the purpose of providing treatment to you, your information may be shared with employees and contractors of the provider, or with other health care providers you are under the care of.
   b. For the purpose of arranging payments of your care, your information may be shared with your insurer or other third-party payer who is responsible for paying all or part of the cost of your care.
   c. For the purpose of health care operations, we may use and disclose information that is necessary for our operations. We may also disclose information to (ie. doctors, nurses, and technicians). We may use information about you to remind you of an appointment for treatment of medical care.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us make a specific disclosure that is not covered under section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

C. We may be required by law to disclose your records that you have not authorized. For example, if we receive a subpoena for the records or if public responsibility required disclose)i.e. To protect the public health).

D. Your rights regarding health information about you:
   a. You have the right to inspect and get a copy of your health information. There will be a fee for copying records. Workers Compensation records may be provided to an attorney or the patient, upon request, at the conclusion of treatment. There will be a fee for copying records.
   b. Your have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical records disclosures made by us except for disclosures made for treatment, payment and health care operations.
   c. You have the right to receive a paper copy of this notice.

E. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated you may complain to us by calling us or writing to us with details. We will not retaliate in any way against a patient making a complaint.

F. We reserve the right to change our privacy practices and to make new policies effective for all protected health information we maintain. If we should do so we will issue an updated "notice to patient" to all of our patents.

Please acknowledge receipt and review of this notice by signing below.

_____ _____

Printed Name Date

_____

Signature