Date:____/_____/_____

Elite PT New Patient Intake Form

Name:_____ **Gender:** Male/Female **Date of Birth:** ____/_____/_____
Phone: (_____)_____ **Email:**_____ **Address:** _____
City: _____ **State:** _____ **Zip:** _____ **Emergency Contact:** _____
Relation: _____ **E.C. Phone:** (_____)_____ **Diagnosis:** _____
Referring Physician: _____
Date of Injury/Accident/Surgery: ____/____/_____ **Rx Date:** ____/____ /_____
Have you had any physical, occupational, or speech therapy this policy year? yes/no

Please be aware that any previous visits may count against your allowable visit amount per plan year or calendar year as determined by your insurance company

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Primary Insurance:_____ **Member ID:** _____ **Group #:** _____
Policy Holder:_____ **DOB:** ____/____/_____ **Relationship:** _____
Secondary Insurance: _____ **Member ID:** _____ **Group #:** _____
Policy Holder: _____ **DOB:** ____/____/_____ **Relationship:** _____
Did this occur playing sports for your school? Yes/No
Will you be using school insurance for your PT? Yes/No
Auto/Worker Claim #: _____ **Insurance Company:** _____
Adjustor Name: _____ **Phone:** _____ **Date of Accident:** _____/_____/_____
Insurance Address: _____ **City:**_____ **State:**_____ **Zip:**_____

IE Date: ____/____/_____ **Time:** _____ **Therapist:** _____ **Other Notes:** _____
_____

Insurance Verification
Representative: _____
In-Network:
Deductible: _____Met? _____
Co-Pay: _____ Co-Insurance: _____
Autorization Needed? _____
OOP: _____
Limits: _____
Cal/Plan Year: _____

Date Verified: ___/____/_____ **Initials:** _____
Policy Effective Date: _____
Out of Network:
Deductible: _____Met? _____
Co-Pay: _____ Co-Insurance: _____
Authorization Needed? _____
OOP: _____
Limits: _____
Cal/Plan Year: _____

Financial Responsibility: I am financially responsible for all charges incurred at Elite PT, LLC. Any portion of these charges not covered by my insurance company must be paid by me. I further understand that all insurance deductibles, coinsurances, and copays are my responsibility to pay and I will make payment directly to Elite PT, LLC. Elite PT, LLC has verified my insurance as a courtesy, but that I should know if my insurance company processes my claims differently, I am responsible for taking care of any unpaid balances. If any balance is turned over to a collection company, I am responsible for fees incurred.
Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to Elite PT, LLC.
Authorization to release info: I hereby authorize Elite PT, LLC to release any info required by my insurance Co.
Consent to Treat: Your signature is required below to authorize treatment. An additional treatment authorization signature is required by a parent/legal guardian for all minors.

HIPAA: I have reviewed the HIPPA privacy laws

Patient Signature: _____ **Date:** _____/_____/_____
Parent/Guardian Signature: _____ **Print Full Name:** _____ **Date:** ____/____/____

Follow along for updates, tips, and more at
www.ElitePT.com
and on our other social pages!

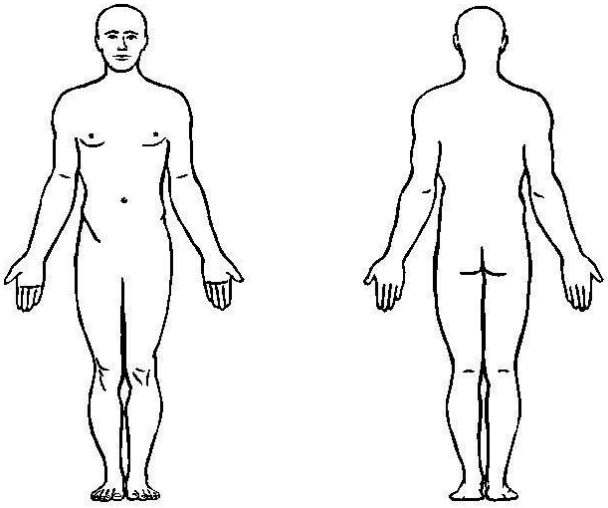
Patient Medical History Form

ELITE pt
Specializing in
Orthopedic, Sports &
Manual Physical Therapy

1. Subjective Information (ie: What problem are we treating? Description of your symptoms)
_____
_____

2. Please **circle** the intensity of your Pain/Symptoms
0-1-2-3-4-5-6-7-8-9-10
(least pain --- most pain)

3. Indicate on the body chart your area(s) of Pain/Symptoms



4. What is the specific cause of injury or series of events leading up to your visit today? _____
_____

5. When did these symptoms start bothering you?
_____

6. How do you alleviate your symptoms?
_____

7. List any movements or activities that aggravate your pain.
_____

8. Describe how your symptoms change during the day?
_____

9. Do your symptoms awaken you because of pain? Yes_____ No_____

10. Age: _____ Occupation: _____

11. Do you exercise? If so, what do you do? _____

12. Is your injury work related, result of a Motor Vehicle Accident, Recreational or Other? Please circle one.
13. Are you Pregnant? ___Yes ____ No
14. Do you have metal plates or screws? ___Yes ____ No
15. Have you had X-Rays, CT scans or an MRI? ___Yes ____ No Dates(s):_____
16. Do your symptoms increase when you cough or sneeze? ____Yes ____ No
17. Any significant, unexplained weight loss over the last 2-3 months? ____Yes ____ No
18. List any Medications you are currently taking: _____
19. Please list surgical history: _____

20. Please **CHECK** next to any conditions that you have experienced in the PAST.
CIRCLE any condition you have CURRENTLY. The answers below are correct to the best of my knowledge.

__Bone or joint disease	__Broken/fractured bones	__Osteoporosis	__Arthritis
__Rheumatoid arthritis	__Tendinitis/bursitis	__Sprains/strains	__Neck, shoulder, arm pain
__Low back, hip, leg pain	__Jaw pain/TMJ	__Spasms/cramps	__Blood clots
__Varicose Veins	__Lymphedema	__High blood pressure	__Low blood pressure
__Hypoglycemia	__Diabetes	__Thyroid problems	__Lupus
__Heart condition	__Chest Pain	__Pacemaker	__Metal Implants
__Bowel/bladder problems	__Irritable bowel syndrome	__Nausea/vomiting	__Cancer/tumors
__Allergies/skin allergies	__Rashes	__Warts	__Athlete's foot
__Herpes/shingles	__Aids/HIV	__Seizures	__Numbness/tingling
__Kidney problems	__Drug/alcohol addiction	__Sleep disorders	__Blurred vision
__Fatigue	__Psychological	__Depression	__Eating disorder
__Headaches/lightheaded	__Sinus problems	__Nicotine/caffeine addiction	
__Breathing difficulties	__asthma	__Gas/bloating/constipation	

If you checked/circled any of the above, please explain: _____
_____

Print Name_____

Signature of Patient or Guardian: _____**Date:** _____

CANCELLATION POLICY

At Elite PT, we take pride in our ability to provide excellent care to our patients. While we understand that unanticipated events happen in life, we do hold our patients to a strict cancellation and no-show policy. In our commitment to offering our patients the personalized care and attention that they deserve, we must abide by the following policy:

- In the event that a patient **cancels the same day** as that appointment and that time-slot is not able to be filled, the patient will be charged a **$50 fee**.
- In the event that a patient **does not show up** to a scheduled appointment, the patient will be charged a **$50 fee**.

In the case of inclement weather, this policy will not take effect

As a courtesy to our patients, automated appointment reminders will be sent to the email on file (if provided) 24 hours prior to the appointment. We ask that you do your best to arrive on time to allow us to fully address your physical therapy needs. Please provide us with as much notice as possible if you cannot make your scheduled appointment, as that time could be filled by another patient.

(initial here) **X**_____

WAIVER OF LIABILITY

I/We hereby understand and acknowledge that the training, programs and events held by Elite PT LLC may expose me to many inherent risks, including accidents, injury, illness or even death. I/We assume all risk of injuries associated with participation including, but not limited to falls, contact with other participants, the effects of weather, including high heat and/or humidity and all other such risks being known and appreciated by me. I/We understand that Elite PT LLC recommends each participant see a physician prior to engaging in any physical training or conditioning programs. I/We represent that I/We have consulted with a physician and that they have cleared us for physical conditioning activities. I/We hereby acknowledge my/our responsibility in communicating any physical and psychological concerns that might conflict with participation in activity. I/We acknowledge that I am physically fit and mentally capable of performing the physical activity in which I choose to participate.

After having read this waiver and knowing these facts and in consideration of acceptance of my participation and that Elite PT LLC and furnishing services to me, I agree for myself and anyone entitled to act on my behalf, to HOLD HARMLESS, WAIVE AND RELEASE Elite PT, LLC., its officers, agents, employees, organizers, representatives, and successors from any responsibility, liabilities, demands or claims of any kind arising out of my participation in Elite PT LLC, training, programs and events.

I have read and understand the aforesaid terms and conditions and I agree that part of the compensation for me to participate in any Elite PT LLC and programs are the terms herein and in return for the waiver and hold harmless agreement.

(initial here) **X**_____

By my signature, I/We indicate that I/We have read and understand this Waiver of Liability and Cancellation Policy. I am aware that this is a waiver and release of liability and I voluntarily agree to its terms.

Client Name (Please Print): _____ Date: _____

Client Signature _____

(Parent's signature if under 18 years of age) I represent that I have legal capacity and am authorized to act on behalf of the minor named herein.

Parent/Guardian Signature: _____ Date: _____