INTAKE FORM

Date: ____________________

Employee: ________________

Full Name: ______________________ Date of Birth: ____________ Age: ________

Gender: ________ Preferred Pronouns: ____________ Social Sec. #: ____________

Address: ______________________ City/State/Zip: ____________

Cell Phone: ______________________ Email: ____________

Home Phone: ______________________ Appointment Reminders: ◘ Text ◘ Email ◘ None

Emergency Contact: ______________________ Contact Phone: ____________

Referring Physician: ______________________ Primary Physician: ____________

How did you hear about us? ○ Friend/Family ○Internet ○Facebook ○Advertisement ○Other: ________

STRESS Level: low 1 ---- 2 ---- 3 ---- 4 ---- 5 high What is the main cause? ____________

NUTRITION: What is your level of nutrition knowledge? ○ none ○ a little ○ medium ○ a lot

ACTIVITY: How often are you active? Frequency: ____________ Duration: ________

What is an activity that you really enjoy doing? ______________________

FITNESS Goals: ○ increase strength & stamina ○ lose weight ○ body toning ○ increase flexibility & mobility

Other: ______________________

IMPORTANT RULES & POLICIES Please initial next to each.

1. ________ Late Policy: If you are **more than 10 minutes late to your appointment, you may be rescheduled or asked to wait for the next available time slot.**
2. ________ **24-HOUR advance notice** is required for changes to an appointment, otherwise a $30 fee may apply.
3. ________ Co-pays and/or deductibles are due prior to treatment.
4. ________ Not showing for an appointment without notice, will result in a $30 fee.
5. ________ Cell phones must be **shut off or silent**. If you need to take a phone call, you may be asked to step outside for the duration. Phone calls during appointments may result in cancellation of appointment.
6. ________ **Children must be supervised at all times** unless they are capable of remaining in the waiting area, without disruption, for the full appointment time.
7. ________ We request that you verify your insurance benefits in addition to any verification done by Physio. It is important that our clients are educated on their insurance coverage.
8. ________ If you are experiencing any financial hardship, please notifiy us immediately so we can do our best to create a payment program that is feasible.
9. ________ If for any reason you are not satisfied with the care received, please let us know! Speak to the office manager, or reach out to 828.348.1780

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Physio Inc. and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Physio, Inc., and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Physio, Inc., or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Physio, Inc. and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Physio, Inc.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE PHYSIO PHYSICAL THERAPY & WELLNESS FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: ______________________

Parent/Guardian Signature: ______________________

Signature: ______________________ Date: ____________

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PHYSICAL THERAPY AND WELLNESS

PRE-EXAM

Date: ______________________________

Employee: ______________________________

Full Name: ____ Age: ______________

Occupation: ______________________________________ Are you working now? ◘ Yes ◘ No

Where is your pain/problem? ____

Please indicate the following on the body to the right using the designated symbols:

/// Stabbing **000** Pins & Needles **ZZZ** Achy

XXX Burning **>>>** Numbness Other: ______________________

What caused your pain/problem?

____

When did it start?

____

On the scale, circle your worst pain level in the last couple of days:

None *0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10* ***Severe*** *(Emergency Room)*

How would you rate your ability to perform activities associated with your job? *(If applicable.)*

Unable to Perform *0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10* ***No Problems***

How would you rate your ability to perform routine daily activities?

Unable to Perform *0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10* ***No Problems***

Have you ever had this same (or similar) pain/problem before? ◘ No ◘ Yes ______________________

List one activity that you are unable to do that you absolutely want to be able to do again? ______________________

How optimistic are you that you'll get better? Please circle one. **Not at all** --- Mildly Optimistic --- Fairly --- Very Optimistic --- **Extremely**

Over the next 30 days, how many hours per week will you commit to getting better? ______________________

MEDICAL HISTORY

List all past surgeries with dates:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

List any medications you are taking:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Check off any other conditions, allergies, chronic conditions, or precautions:

◘ Allergies
◘ Anemia
◘ Anxiety
◘ Arthritis
◘ Autoimmune Disorder
◘ Cancer
◘ Cardiac Conditions
◘ Cardiac Pacemaker
◘ Chemical Dependency
◘ Circulation Problems
◘ Currently Pregnant
◘ Diabetes
◘ Dizzy Spells
◘ Emphysema/Bronchitis
◘ Fibromyalgia
◘ Gallbladder Problems
◘ Headaches
◘ Hepatitis
◘ High Cholesterol
◘ High/Low Blood Pressure
◘ HIV/AIDS
◘ Incontinence
◘ Kidney Problems
◘ Metal Implants
◘ MRSA
◘ Multiple Sclerosis
◘ Muscular DIsease
◘ Osteoporosis
◘ Parkinsons
◘ Rheumatoid Arthritis
◘ Seizures
◘ Smoking
◘ Speech Problems
◘ Strokes
◘ Thyroid Disease

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/ therapist will determine whether or not I am a viable candidate for a rehabilitiation program and that my approval into their program is not guaranteed.

____

Patient/Guardian Signature ***Date***

Informed Consent and Policies Agreement

Medical Necessity
All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measurable and trackable?

If the above criteria are not met, you are welcome to participate in our elective services such as SmartLaser, massage, myofascial treatments, fitness/exercise training, ASTYM, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late
Please refer to the Intake Registration Form.

Authorization for Release of Records
Assignment of Benefits (for insurance patients)
Please refer to the Assignment of Benefits form.

Results
The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients
It is your responsibility to know your benefits and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients
If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents
If the patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Method of Contact & Image Release
I hereby give my consent for Physio, Inc. (Physio) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

- Call my home or other alternative location and leave a message on voicemail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient billing statements.
- Contact me by phone, mail, text or email to participate in marketing events, pertinent products or services offered by Physio.
- Use any photos or videos of me for promotional purposes on the internet or within the office.
- E-mail, mail or text message to my home, or other alternative location any, items that assist the practice in carrying out TPO, such as appointment reminders, patient billing statements, home exercise programs or reminders and updates from my therapist and their team.
- I have the right to request that Physio Physical Therapy & Wellness restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Physio to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Physio may decline to provide treatment to me.

Informed Consent
By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to the patient/caretaker to inform the therapist/staff about any health problems or allergies the patient may have. The patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.
Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration
The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me

Patient Signature/Date

Patient's Representative Signature/Date

Witness Signature/Date

Relationship to Patient

PHYSIO Physical Therapy & Wellness

Statement of Privacy Notice

Effective June 1, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (828) 348-1780. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (828) 348-1780. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Physio, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____
Patient's Signature Date

____
Authorized Facility Signature Date

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PHYSICAL THERAPY AND WELLNESS

ASSIGNMENT OF BENEFITS

Date: ______________________________

Please select from the following payment choices by initialing the box to the left of the payment choice you make.

	SELF PAY: Please pay the balance in full at the time of service. In the event that you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised that we are not a credit grantor, and therfore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection.
	PRIMARY & SECONDARY INSURANCE: We will bill your primary and secondary insurance carriers that you have listed below. We assume payment of insurance benefits is not forthcoming on charges older than 120 days. Charges outstanding for more than 120 days from the date of filing will be due in full from you, regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been fully processed by your insurance carrier.
	WORKERS COMPENSATION: We will bill your Workers Compensation Carrier for your charges. Please note that you will remain financially responsible for any and all charges if your carrier denies coverage or your claim is controverted. You are also financially responsible for any and all services deemed elective, as well as any accrued cancellation/no-show fees.

Benefit Info:

What is your deductible amount? $ ______________ How much of your deductible have you paid already? $ ____________

What is your copay $ _________ and/or coinsurance? _________ % Are there any maximums? ______________________________

Have you had any of the following services? ◘ Chiropractic ◘ Home Health ◘ Occupational/Speech Therapy

Initial: _______________ *(If you don't know this information, call the customer service number on the back of your insurance card.)*

Policy Info:

Patient Name: ____ DOB: ________________________

Policy Name: ____

Primary Insurance ID: ____ Group #: _____________________________________

Secondary Insurance ID: ____ Group #: _____________________________________

***If you are insured through someone else's policy, please fill out the following:*

Policy Holder's Name: ____ DOB: _______________ SSN: _____________________

Address: ____

Relationship to patient: ◘ Spouse ◘ Parent ◘ Other: ____

Is this injury/condition related to an auto or work accident? ◘ Yes ◘ No Date of Injury: _______________________________

Where did the accident occur? ◘ Work ◘ Car ◘ Other: ____

Insurance Adjuster: *(if applicable)* ____ Phone: _____________________________

Attorney: *(if applicable)* ____ Phone: _____________________________

I hearby instruct and direct ____________________ insurance company to pay by check made out to "Healthcare Provider" below and mailed to the address below, not mine. If my/this current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make the check out to me and mail it to the address below for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider Information:

Physio Physical Therapy and Wellness	Phone: (828) 348-1780
660 Merrimon Ave Suite C	Fax: (877) 922-4820
Asheville, NC 28804	Email: info@physiownc.com

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

◘ A photocopy of this Assignment shall be considered as effective and valid as the original.

◘ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payments.

◘ I authorize the use of this signature on all insurance submissions.

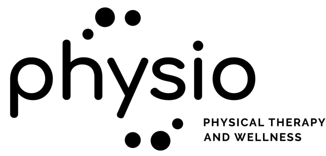
◘ I authorize the "Healthcare Provider" named above to deposit checks made in my name.

◘ I authorize "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

◘ I understand that I am financially responsible for all charges not paid by my insurance.

Dated this ________ day of ________ , 20_________.

______________________________	______________________________	______________________________
Signature of Policy Holder	*Witness*	*Signature of Claimant, if other than Policyholder*



Credit Card On File Agreement

If you would like to maintain a card on file with Physio, please complete the following:

- ○ I, ______________________ authorize Physio Physical Therapy and Wellness to charge to my credit or debit card for the following reasons: Co-pays or co-insurance, cancel or no show fees, massages, laser, dry needling, and any other item and/or service that I give verbal or written permission for.
- ○ I agree to be charged each visit period for the total amount due for that visit.
- ○ I understand that I can request receipts at any time.
- ○ I agree that no prior notification will be provided if the total payment is under $150. If my bill is more than that amount, I will receive notice from us at least 1 day prior to the payment being collected.
- ○ I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Cardholder Name: ______________________________________ Zip Code: __________________

Account Number: _______________________________________ Expiration Date: _____________

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX): _________________________

______________________________________ ______________________________________
Full Name Date Physio Representative Name Date

______________________________________ ______________________________________
Signature Signature

If you would like to opt-out of maintaining a card on file with Physio, please complete the following:

I, ______________________ , would like to opt out. Please **DO NOT** keep my card on file.

______________________________________ ______________________________________
Full Name Date Physio Representative Name Date

______________________________________ ______________________________________
Signature Signature

What to Ask Your Insurance

Even though we are in-network with most major plans, there are many different types of insurance plans, and coverage varies.

Please note, that if you do not verify the following questions, you may receive an unexpected bill. By verifying your benefits ahead of time, you could save yourself from overpaying at the time of service.

Is Physio in-network? ◯ Yes ◯ No

Physio's National Provider Identifier (NPI) is 1588920342. (If your insurance is a CIGNA plan, please provide the tax ID 11-3670557to ensure you are requesting your physical therapy benefits summary appropriately.)

What are the effective dates of my insurance? ________________________________

Have I met my deductible? ◯ Yes ◯ No

If not, how much is left on my deductible? ________________________________

Does my deductible apply to Physical Therapy? ◯ Yes ◯ No

What is my co-pay/co-insurance for Physical Therapy? ________________________

How many Physical Therapy visits are allowed per year? ______________________

Name of Representative you spoke with: ________________________________

Call Reference Number: ____