tri physical therapy

PHYSICAL THERAPY PILATES MEDICAL MASSAGE

NEW PATIENT INTAKE

Date: _____

Patient Name: _____ DOB: _____ M F *(Circle)*
First MI Last

Mailing Address: _____
City State Zip

Cell Phone: _____ Work/Home Phone: _____

Email: _____

How did you hear about us? _____

If Minor, Parent/Guardian Name: _____ DOB: _____ Relationship: _____

Marital Status *(Circle):* SINGLE MARRIED DIVORCED MINOR WIDOWED OTHER:

Employer: _____ Job Title: _____
Check Where Applicable: □Computer Work? Hrs/Day: _____ □Prolonged Driving? Hrs/Day: _____ □Heavy Lifting? Lbs/How Often: _____ □Pushing/Pulling? Explain: _____

Who referred you to Tri-PT *(Circle)*: Surgeon Rehab Physician Patient: _____ Other: _____

Family/Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Insurance Information:

(If you have your insurance card, no need to fill this section out, just give card to the receptionist so we can make a copy)

Primary Insurance

Insurance Carrier: _____ Member ID #: _____ Group #: _____

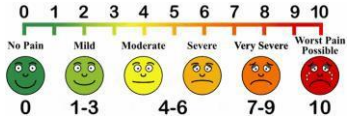
Policy Holder Name: _____ DOB: _____ Phone # on Back of Card: _____

Relationship to Patient: Self Spouse Child Other: _____

Do you have a secondary insurance? □ Yes □ No If yes, what insurance? _____

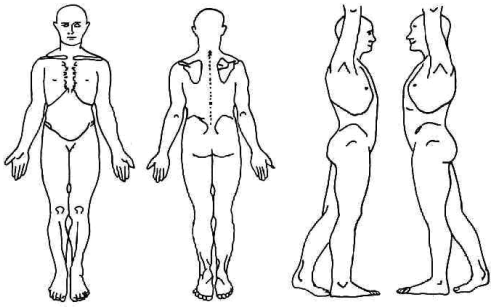
MEDICAL HISTORY

On a scale from 0-10 Please list your pain:



Pain Scale: _____

On the provided drawing to the right, *please circle* any specific areas you experiencing pain/symptoms.



Are You Currently Taking Any Prescription or Non-Prescription Medications: ☐ Yes ☐ No

Anti-Inflammatories	Yes	No	_____
Muscle Relaxers	Yes	No	_____
Pain Medication	Yes	No	_____
Other	Yes	No	_____

Have you had any of the following diagnostic, medical, or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
General Practitioner	_____	_____	Chiropractor	_____	_____
Orthopedist	_____	_____	CT Scan	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Physical Therapy	_____	_____	X-Rays	_____	_____
Emergency Room Care	_____	_____	EMG	_____	_____
Neurologist	_____	_____			

Do you now or have you ever had any of the following? *Place X where applicable below*:

Asthma, Bronchitis, or Emphysema	High Blood Pressure	Anemia
Shortness of Breath/Chest Pain	Heart Attack or Surgery	Diabetes
Coronary Heart Disease or Angina	Thyroid Trouble/Goiter	Gout
Cancer/Chemotherapy/Radiation	Dizziness or Fainting	Weight Loss/Energy Loss/Weakness
Emotional/Psychological Problems	Infectious Diseases	Hernia
Bowel or Bladder Problems	Numbness or Tingling	Allergies
Migraines/Headaches	Elbow/Hand Injury	Osteoporosis
Vision or Hearing Difficulties	Neck Injury/Surgery	Stroke/TIA
Sleeping Problems/Difficulties	Back Injury/Surgery	Blood Clot/Emboli
Leg/Ankle/Foot Injury/Surgery	Knee Injury/Surgery	Epilepsy/Seizures
Do you have a Pacemaker?	Pelvis Injury/Surgery	Varicose Veins
Any Pins or Metal Implants?	Arthritis/Swollen Joints	Incontinence
Joint replacement	Are you pregnant? Weeks:	Organ Prolapse
Do you smoke?	# of Pregnancies: Vaginally or C-section	Diastasis Recti

Please list the types of surgeries you've had done and the year the surgery was performed. _____

Please list any additional information that would assist us in providing you with treatment (Date of Injury/Onset) _____

Are you Left handed or Right handed? **L** **R**

Based upon your awareness of your diagnosis, what are your expectations/goals while being treated in our office?

Medical History - Massage

The following information will be used to help plan safe and effective massage sessions at Tri-Physical Therapy. Please answer the questions to the best of your knowledge.

1. Have you had a professional/medical massage before? Yes No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain_____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain_____
4. Do you have sensitive skin? Yes No
   If yes, please explain_____
5. Are you wearing: contact lenses ( ) dentures ( ) hearing aid ( )
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain_____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain_____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   Muscle tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other:_____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
   If yes, please identify_____
10. What are your goals for this massage/Myotherapy session?
    Please explain_____

Please check any condition listed below that applies to you:

_____contagious skin condition	_____joint disorder/RA/ osteoarthritis/tendonitis	_____TMJ
		_____high or low blood pressure
_____phlebitis	_____current fever	_____circulatory disorder
_____open sores or wounds	_____decreased sensation	_____varicose veins
_____deep vein thrombosis/ blood clots	_____swollen glands	_____atherosclerosis
	_____allergies/sensitivity	
_____easy bruising	_____Fibromyalgia	

Please explain any condition that you have marked above_____

_____

_____

Informed Consent for Physical Therapy Services

Physical Therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Tri-Physical Therapy, Inc does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

In conjunction with my care, I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to Tri-Physical Therapy and/or the treating physician through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that Tri-Physical Therapy will not further use or disclose such film or images for any other purpose without my authorization or consent.

☐ **Yes** ☐ **No**

In addition, we may occasionally take pictures/video for our social media pages (i.e. Facebook and Instagram), would you be willing to allow Tri-Physical Therapy to utilize approved pictures/video of you with your consent?

☐ **Yes** ☐ **No**

I have read the Informed Consent for Physical Therapy Services section in it's entirety and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Printed Name: _____

Signature: _____ **Date:** _____

Massage Waiver of Liability and Informed Consent Release

Patient Name: _____ **DOB:** _____

The purpose of the area below, is to clarify your responsibilities as a client/patient so that we focus our efforts on helping you achieve your optimal results in the shortest amount of time.

Please take a moment to read and *initial* all the following statements:

_____ I understand that the massage/Myotherapy I receive at Tri-Physical Therapy is provided for relief of muscular tension, increase blood flow, decreasing overall pain, and improving flexibility.

_____ If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

_____ I further understand that massage therapy/Myotherapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical physician.

_____ I understand that massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

_____ Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

_____ I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ This is a Therapeutic/Medical Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary. Male and female genitalia and women's breasts will not be exposed or touched at any time.

Informed written consent must be provided by a parent or legal guardian for any client under the age of 17 (see receptionist for waiver).

Patient Signature: _____ **Date:** _____

Pilates Waiver of Liability and Informed Consent Release

This release, waiver, and Hold Harmless Agreement is made by and between the undersigned (client) and Tri-Physical Therapy, and entered on the day month and year below.

Tri-Physical Therapy provides space for instruction in the Pilates method of physical conditioning. The parties to this agreement recognize that participation in this activity could lead to physical injury to the client. Client desires to undertake Tri-Physical Therapy's program with the full knowledge of the possibility that physical injuries could result from it and desires to assume the risk of any such injury.

The parties recognize that Tri-Physical Therapy will not be able to provide it's program to client(s) without the execution of the agreement.

Therefore, the client in consideration of the above and the exercise classes to be provided, herby waives all claims for damage or loss to personal property which may be caused by any act, or failure to act of Tri-Physical Therapy instructors, staff, partners or employees. Client assumes risk of all dangerous conditions in and around the premises and waives any and all specific notice of the existence of such conditions. Client also assumes the risk of any and all injuries that might result from participating in Tri-Physical Therapy exercise programs.

By signing below, you are agreeing that you have enrolled in a program of physical activity including but not limited to the use of various Pilates machinery offered by Tri-Physical Therapy. I understand that participation in the Pilates Method exercise and conditioning activities, like any physical conditioning activity or exercise program, presents some potential risk of injury, especially to people who have pre-existing injuries, muscle movement patterns, illness or medical disabilities. I herby affirm that I have and will keep Tri-Physical Therapy fully informed of any, existing physical condition or disability which would prevent or limit my participation in an exercise or physical conditioning program. I will also keep Tri-Physical Therapy informed of any physical condition or disability arising from my participation in Tri-Physical Therapy exercise program, I, my heirs and assigns, herby release Tri-Physical Therapy from my liability, now or in the future, including but not limited to heart attacks, muscle strains/pulls or tears, broken bones, shin splints, heat prostration, knee, lower back, foot, injuries and other illness, soreness, or injury however caused, occurring during or after participation in the exercise program.

I herby affirm that I have read and fully understand the above, am over eighteen years of age, or am a legally emancipated minor.

Client Printed Name:_____

Client Signature: _____ **Date:** _____

Patient Financial Responsibility

Tri-Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. *However, you are ultimately responsible for the payment of your bill.*

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at our office or mailed to the address on your statement.

I have read the above policy regarding my financial responsibility to Tri-Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Tri- Physical Therapy. I agree to pay Tri-Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____(relationship to patient: if not self: _____)

Printed Name: _____Date: _____

Please note that the information included in this Statement of Financial Responsibility form is subject to any applicable state laws, rules or regulations that impact your financial responsibility and whether there is an amount owed

24 Hour No Show/Cancellation Policy

At Tri-Physical Therapy, we value the time you commit to us in order to achieve your healthcare goals. We hope you value our time as well. We pride ourselves in offering our patients one-on-one treatments to ensure the highest quality of care. While this level of integrity is not common in most medical facilities, we believe that it is what each patient deserves when they are being treated in our office. This means that each time you come in, one of our team members has reserved that specific time to work with you. In order to maintain this level of care, it is imperative that any patient that needs to reschedule or cancel their appointments do so in a timely manner.

This time frame is 24 Hours from the time of your appointment
In order to ensure that we can continue to deliver the same caliber of care to our patients, we will be enforcing a cancellation fee for all appointments cancelled or rescheduled within 24 hours of the schedule time of the appointment.

Cancellation fee will be $40.00 (per scheduled appointment for that day) and will be charged at the time of your next appointment via cash, debit, or credit card (swipe only). We appreciate your understanding of this policy and valuing our time as much as we value yours.

I_____**(name)** Acknowledge the Tri-Physical Therapy cancellation policy. I understand that I will be charged the indicated fee if I cancel or reschedule an appointment within 24 hours of my appointment.

Patient Signature: _____Date: _____

tri physical therapy

PHYSICAL THERAPY PILATES MASSAGE THERAPY

Health Insurance Carrier Consent & Agreement

On your behalf, we are pleased to file your care to your insurance company. Please be aware, however that since we are out of network and often out of state, the check for these services ***might*** be issued to you and in your name. By signing below, you are agreeing that you understand that payment will be issued to you and that you will be required to forward the check(s) to you as a payment for services rendered.

If bringing insurance checks is difficult for you, we have a couple of options for you:

1) We can provide you with a stamped, self-addressed envelope to forward all checks to us. Please open all correspondence from your insurance carrier, as it often is difficult to recognize that checks are enclosed. Please forward payment to us immediately. If you have any questions, feel free to contact us at: (602) 956-1233.

2) Please be aware that if you have signed up (with your insurance carrier) to receive electronic *EOB's, your checks issued may not include a copy enclosed when payment is sent/addressed to you. If this is the case, it will be your responsibility to forward the EOB pertaining to the date of service issued on the check. The quality of your care and services within our facility are essential! If you have any questions, feel free to contact us.

Thank You,

Tri-Physical Therapy
Billing Department

_____ _____

Patient Signature **Date**

_____

Patient's Printed Name

An **explanation of benefits (commonly referred to as an **EOB** form) is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB is not a bill. It simply explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid and any balance you're responsible for paying the provider. It also tells you how much has been credited toward any required deductible.*

Patient Notification Policy

(Notice of Privacy Practices: HIPAA)

Patient Name: _____

DOB: _____

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, Tri-Physical Therapy will not disclose your Protected Health Information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment, and health care operations. Furthermore, Tri-Physical Therapy will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Tri-Physical Therapy will only disclose your appointment information, such as reminders or cancellations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise.

I, the undersigned, hereby authorize Tri-Physical Therapy to disclose my general health information and appointment reminders by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable:

Please initial if you are okay we contact you via:

Home/Cell Phone/Voicemail: _____

Text Message: _____

E-Mail: _____

Patient/Guardian Signature: _____ Date: _____

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. I further agree to be responsible for notifying Tri-Physical Therapy if any of the foregoing change.

I, the undersigned, hereby authorize Tri-Physical Therapy to disclose my PHI to the person(s) named below.

Name	Relationship	Phone #
Name	Relationship	Phone #

Patient/Guardian Signature: _____ Date: _____