Intecore
PHYSICAL THERAPY

Welcome to Intecore Physical Therapy, we are pleased to have you as a new patient, and are looking forward to taking care of all your physical therapy needs. Below is some information to help you achieve the most from your therapy visits.

WHAT TO BRING:

- Insurance card
- Driver's License
- Completed patient intake forms
- Prescription from doctor
- List of medications

- Please BE ON TIME to your appointments-Please call the clinic if you are going to be late.
- Please dress appropriately for physical therapy appointments and make sure that the affected joint can be easily exposed so that your therapist may better evaluate and/or work on the joint. We recommend shorts/sweats, t-shirts, workout clothing and athletic shoes.
- *Consistency*- In order for you to attain your rehabilitation goals it is necessary that you attend physical therapy consistently to ensure a timely recovery. It is important to make this physical therapy a priority to help you regain your prior level of function.
- *Please schedule your appointments* out for the duration of your prescription to ensure you get the most convenient times for you; we are a busy clinic and time slots fill up quickly.
- *Confirmation calls*- Automated confirmation calls are made prior to your physical therapy appointments. Due to circumstances beyond our control, you may not receive this reminder call, please do not rely on the confirmation call to remind you of your physical therapy appointment. We will provide you a print out of your schedule at your first visit and at any time you update your schedule.
- We are contracted with most major insurance companies and will bill the insurer directly. We also strive to meet the varying needs of our patients with flexible payment plans if that need arises. Our therapist are certified for direct access which allows us to treat without physician referral, this may not be covered by all insurance plans.

First Treatment: Your therapist will interview you, evaluate your condition, and establish and individualized treatment programs for you. This initial evaluation may take up to 1 hour and 15 minutes.

Future Treatments: The therapist may use methods such as therapeutic exercise, joint and soft tissue mobilization, electrical stimulation, heat/cold therapy and patient education. Future visits may include warm up exercises you have already learned, and will progress through the course of your rehabilitation. Most treatment sessions will last between one hour and 1 hour and 15 minutes.

Home Treatment: During the course of your rehabilitation, your therapist will prescribe a home exercise program to be carried out on your own. This is an important part of your treatment program. In most cases, two to three hours a week spent in physical therapy is not enough time to improve function.

We Value Your Business!

We understand that there are many choices for physical therapy treatment, and are proud to be able to offer you the best possible care available. If there are ever any concerns or questions before, during, or after your treatment, please do not hesitate to contact our staff immediately, whether in person, by phone, or email. We are continually working hard to be The Source for Health and Wellness in our Community! If you enjoyed your time with us -we encourage you to share your experience!

Intecore
PHYSICAL THERAPY

NEW PATIENT FORM

PLEASE PRINT CLEARLY W/ BLACK INK

Date:_____

Name (Last) _____ (First) _____ (M.I.) _____

Birth Date_____ Social Security_____ Age _____Sex: M / F

Home Address_____

City_____ State_____ ZIP_____

Area to be treated_____ Date First Consulted_____ Injury Date _____

Home Phone (_____)_____ Work Phone (_____)_____ Other Phone (_____)_____

Email _____ How shall we contact you? (circle) Home Ph. / Cell Ph. / E-mail / Text

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Employment Full / Part-time / Not Working / Retired **Employer**_____

Emergency Contact_____Relation_____ Phone_____

Referring Physician_____ Telephone _____

How did you hear about us? ☐ Friend/Relative _____ ☐ Internet ☐ Yellow Pages ☐ Physician ☐ Other_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____ Is an attorney involved? Yes / No

Attorney name _____

Address _____ Telephone # (_____) _____

Patient Signature:_____**Date:**_____

(OFFICE USE ONLY)

Intecore PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name _____ Age _____

Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment _____

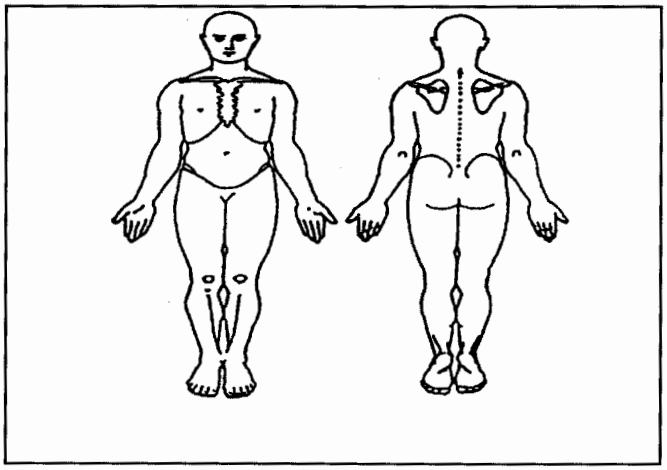
Describe previous treatment for this condition _____

_____

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



Please mark the area(s) of concern

Have you had any imaging performed? :

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted any of the following? :

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision or Hearing
- ☐ Insomnia

Do you have now or have you ever had any of the following? :

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Please explain & give approximate dates for any items indicated above _____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

_____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 / At its best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

_____

What are your physical or fitness goals? : _____

_____

Is there anything else you would like to include or ask your physical therapist? : _____

_____

X _____ _____

Patient or Personal Representative Signature **Date**

Intecore PHYSICAL THERAPY

CLINIC POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Intecore Physical Therapy** to treat the minor patient named in the attached forms while I am not present. _____
Initial

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered. _____
Initial

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Intecore Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____
Initial

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Intecore Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered. _____
Initial

FINANCIAL POLICY – PLEASE READ: We bill your personal insurance carrier solely **as a courtesy to you**. You are responsible for your bill. Per the contractual obligations we have with your insurance company, **we are required to collect all payments at the time of treatment** unless payment arrangements are made prior to your treatments. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in-full, from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits, as quoted to us by your insurance carrier, have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you, and you agree to pay your portion of this bill. _____
Initial

Co-Pay	Co-Insurance
Estimated Co-Pay $_____/visit Deductible $_____/year	**Estimated** Co-Insurance $_____/visit Deductible $_____/year
_____ **Will pay each visit** _____ **Will pay weekly in advance**	_____ **Will pay portion of deductible each visit** _____ **Will pay Co-Insurance each visit**

The above Financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian _____ **Date** _____

Clinic Representative _____ **Date** _____

Form Updated June 2019

Intecore PHYSICAL THERAPY

24 HOUR CANCELLATION POLICY

To Our Patients Regarding Cancellations and No Shows:

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether or not you succeed in your treatment. You referring doctor or Therapist has prescribed a frequency of treatment and maintaining your scheduled visits is your highest priority.

- We require a 24-hour notice in the event of a cancellation. It is your responsibility, when you call, to have an alternate time in mind that will ensure you attend the entire number of prescribed treatments for each week.
- There is a $50 charge for a cancellation without proper notice. This charge is NOT covered by your insurance and will have to be paid by you personally.
- For worker's compensation and personal injury patients, documentation of any missed appointments will be forwarded to your Case Manager, and Primary Physician and this can jeopardize your claim.

In an instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, we reserve the right to charge a $50 fee.

1. After the 1st offense a credit card number will be requested, if not already on file, to collect the **$50** fee.
2. After the 2nd offense the fee will increase to our standard cash rate of **$100** and will remain for all subsequent infractions.
3. Cancellation and No-Show fees are to be paid prior to the following appointment. You may not be able to be treated until fees are paid.
4. In addition, 3 offenses without payment may result in the loss of your physical therapy benefits. We reserve the right to cancel all future appointments and withhold scheduling future appointments.

X_____ **(Patient Initial)** _____**(Staff Initial)**

When you do not attend as scheduled, three people are being hurt by the action: 1) you--because you did not receive your treatment as prescribed; 2) the therapist—who scheduled the time for you, and your treatment; 3) another patient who could have been scheduled if proper notice was given.

Please co-operate with our Cancellation and No-Show policy; it benefits all. We are looking forward to working with you!

X_____ _____

Patient (Guardian) Signature: Date:

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

X_____ _____

Signature of Patient or Representative Date

X_____

Patient's Name

X_____

Date of Birth

_____

Social Security Number

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

---

A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____

Signature of Authorized Clinic Representative Date

Intecore
PHYSICAL THERAPY

Pre-Authorized Healthcare Form

I authorize ***Intecore Physical Therapy*** to keep my signature on file AND to charge my Visa/Mastercard/AmEx/other account as indicated below:

Check one: ____Mastercard _____Visa _____AmEx _____Other

Name on Card: _____

Credit Card # (last 4-digits): _____
(we are compliant with the law & your credit card information is encrypted and kept in a secure file)

Expires: _____ CVV Code: _____

☐ Balance of charges not paid by insurance within 90 days and not to exceed $_____

☐ Recurring changes (on-going treatments) of $_____ from _____ (date) to _____ (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice directly to Intecore Physical Therapy.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Address

_____
City State Zip

_____
Cardholder Signature Date

Form updated April 2019