TEAM REHAB

22 EAGLE ROAD, DANBURY CT 06810

PATIENT INTAKE FORM 2024

PATIENT INFORMATION

NAME		DATE OF BIRTH / /
ADDRESS		
HOME PHONE	MOBILE	WORK PHONE
EMAIL ADDRESS	AUTHORIZED TO LEAVE MESSAGE: [ ] HOME [ ] MOBILE [ ] WORK [ ] EMAIL	

PRIMARY CARE OR REFERRING DOCTOR:

HAVE YOU HAD PHYSICAL THERAPY IN 202___ [ ]YES [ ]NO HOW MANY? _____

EMPLOYER: _____ **ADDRESS:** _____

PHONE#: _____

BILLING INFORMATION

HEALTH INSURANCE [ ] SELF PAY[ ] WORKER'S COMP [ ] MVA [ ] (MUST HAVE MEDPAY WITH YOUR INSURANCE) OTHER [ ]

INSURANCE COMPANY:		ID#
NAME OF INSURED, IF OTHER THAN PATIENT	RELATIONSHIP	DATE OF BIRTH ____/_____/_____

SECONDARY INSURANCE:		ID#
NAME OF INSURED, IF OTHER THAN PATIENT	RELATIONSHIP	DATE OF BIRTH ____/_____/_____

MVA DATE OF INJURY:	W/C DATE OF INJURY:
CLAIM #:	
ADJUSTOR:	PHONE #:
COMPANY:	
ADDRESS:	

REVISED 11/30/2023

Signature of Patient or Legal Guardian:_____Date:___/____/____

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Name: _____

Date: _____

Please provide your doctor and/or physical therapist with a **complete** list of any prescriptions, over-the-counter medicine, herbals, and vitamin/mineral/dietary (nutritional) supplements you are presently taking. Please notify our staff if you make any changes.

Name	Dosage	Frequency	Method of Administration (Oral, Inject, etc.)

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GENERAL POLICY

I, _____authorize the staff of Team Rehab, P.C. to perform such procedures as may be deemed necessary for me or my minor child.

_____ Initial I authorize Team Rehab, PC to release information necessary to process this claim to my health insurance carrier, Medicare, Workers Compensation, and Auto. I hereby assign to Team Rehab, P.C. all payments for medical services rendered to me or my dependents.

_____ Initial **I understand that Team Rehab, P.C. will assist in obtaining prior authorization for medical treatment. Team Rehab, P.C. is not responsible to know or keep current with the status of your copay, deductible, co-insurance, and requirements such as referrals or prior authorization. Any gaps in authorization or non-payment of services for which Team Rehab can legally transfer the balance to the patient will be my responsibility to pay. This includes denials of payment due to reaching my maximum benefit limit, Med Pay exhaustion, Medicare Therapy Threshold when a signed Advanced Beneficiary Notice has been obtained, and other denials unrelated to routine contractual adjustments between Team Rehab and your carrier.**

_____ Initial Your Insurance Plan contract is an agreement between you and your insurance company. We recommend that you contact your Insurance Company if you have an questions about the accuracy of the information our insurance specialists have received.

FINANCIAL POLICY

_____ Initial Copays/Late Payments: I understand that all copays and deductibles will be paid at the time of the service**. If payment is not received at the time of the service, a $10 charge will be added to the copay/deductible** amount for each date of service. Each month, I will receive a statement of services which is due and payable within 30 days of services rendered. If my payment is late and I do not communicate with the billing staff, an interest charge will accrue at the rate of 1.5% per month beginning 60 days following the date that services were rendered. **After 90 days, my account will be placed in collections, and I am responsible for any court costs and related collection fees incurred**.

_____ Initial Insurance Card: I understand that if I do not present my insurance card or Team Rehab is unable to verify my coverage, I am responsible for the payment of services rendered to me.

_____ Initial Insurance Coverage: I understand that if my insurance terminates or changes during my treatment and I do not notify Team Rehab in a timely manner, I am responsible for payment of the visits during the non-coverage period.

_____ Initial Returned Checks: I understand that all returned checks will be subject to an additional $25.00 service fee.

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_____ Initial Missed Appointments: **I understand that I am responsible for any missed appointments that were not cancelled within 24 hours. I am aware that Team Rehab charges $50.00 for follow up physical therapy visits, and $75.00 for new evaluations. Physician visits are charged at $75.00 for follow up visits and $150.00 for new evaluations.**

_____ Initial If you meet your maximum benefit limit, or your insurance does not authorize additional visits, or you do not have insurance, we offer a **self-pay rate** for Physical Therapy with a fee for an Initial Evaluation of $150.00, a Re-evaluation of $90, and a follow-up visit of $75.00. Physician self-pay rates for New Patient visits range from $200-$450 depending on the level of complexity, and $100-$250 for Established Patient visits.

_____ Initial **Our office does not participate in Medicaid or Husky**. We do not accept it as your primary or secondary insurance. While our office encourages you to find a participating provider, you have opted to receive services at Team Rehab and understand **you are responsible for payment** at our self-pay rate at the time of service.

I hereby have read and understand the Financial Policy. I guarantee payment of all charges incurred for me/my minor child's account.

Signature of Patient or Legal Guardian:_____Date: ___/____/____

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PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements of H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on n your prior consent.

I authorize Team Rehab, P.C. to release my records and any information requested to the following individuals.

1. _____

Relation to Patient: _____

2._____

Relation to Patient: _____

3._____

Relation to Patient: _____

Authorization Regarding Messages

(Please check all that apply)

____I authorize you to leave a detailed message on my home or cell number regarding appointments.

___I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

___I authorize you to leave a message with anyone who answers the phone.

___Messages may only be left with _____Date _____

Signature of Patient or Legal Guardian:_____Date: ___/____/____

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ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have reviewed and understand the HIPPA policies on our website and or our office waiting room and I understand that I may request a copy if I so choose.

Patient Signature: _____Date: _____

Print Name: _____ Date of Birth: _____

AUDIO/VIDEO ACKNOWLEDGEMENT

Please be advised, that in order to better enable us to assure compliance with HIPAA privacy and security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited.

We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Patient Signature: _____Date: _____

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NAME_____**DATE**_____

Welcome to Team Rehab. The purpose of this questionnaire is for your therapist to better understand your problem(s). Please answer the following questions to the best of your ability. Thank you!

General Health **Please Circle**

1. Have you had any illnesses within the last 3 weeks (e.g. colds, influenza, bladder or kidney infection)? If yes, please list Yes No

2. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? Yes No

3. Have you had any unexplained weight gain or loss in the last month? Yes No

4. Do you smoke or chew tobacco? Yes No
   If yes, how many pack/day? _____
   For how many months or years? _____

5. Do you have a pacemaker, transplanted organ, or metal implants? Yes No
   If yes, explain_____
   _____
   _____
   _____

6. Height_____ Weight_____

Please see attached sheet for Medication Information

1. Have you had any x-rays, sonograms, computed tomography (CT) scans, magnetic resonance imaging (MRI), or lab work done recently? Yes No
   _____
   _____

2. Please list any previous operations and the date(s):
   Operation Date
   _____
   _____
   _____

Work Environment

1. Occupation: _____

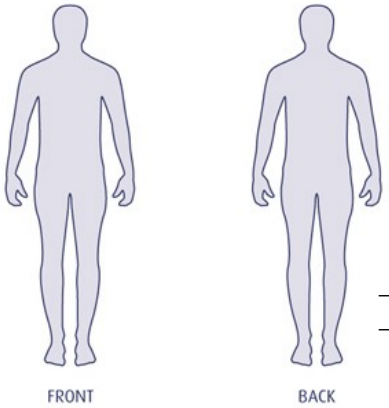
2. Does your job involve:
   [ ] Prolonged sitting (e.g. desk, computer, driving) [ ] prolonged standing (e.g. sales clerk)
   [ ] Prolonged walking (e.g. mill worker, delivery service) [ ] Lifting, bending, twisting, climbing, turning

3. Do you use any special supports:

[ ] back cushion, neck cushion [ ] back brace, corset
[ ] other kind of brace or support for any body part

4. History of falls: [ ] I have no falls [ ] I have just started to lose my balance/fall
[ ] I fall occasionally [ ] Certain factors make me cautious (e.g. curbs, ice, stairs)

To better understand your symptoms, please answer the following questions as best as possible:
Indicate in the diagram where you feel your symptoms



Describe your current symptoms (e.g. sharp, achy, etc.)
_____
_____

Did your symptoms begin due to a specific event?
[ ] car accident [ ] fall [ ] slowly without injury [ ] work related

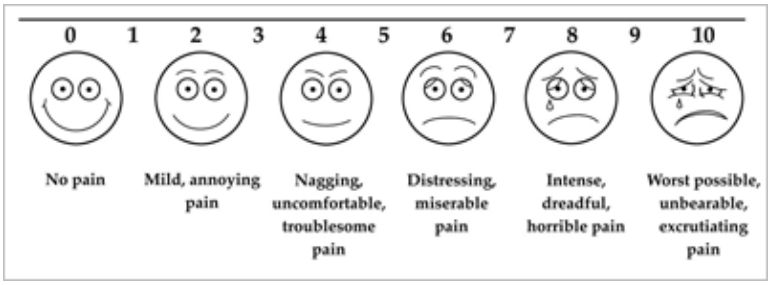
If other, please describe: _____
_____
_____

Have your symptoms changed since the initial onset or injury? [ ] Yes [ ] No
If yes, please describe _____
_____

Please list things that make you feel better (e.g. activity, positions, ice, heat, etc.)
_____
_____
_____

What aggravates your symptoms?
_____
_____
_____

Visual Analog Scale



Please rate your pain using the pain scale below:

Now _____

Average Pain_____

Worst Pain _____