North Boulder
Physical Therapy
Sports Rehabilitation, LLC
A Sister Clinic To North Boulder Pilates

Payer:

3000 Center Green Dr Suite 110
NW Corner of Valmont & Foothills Pkwy
Boulder, CO 80301
Phone (303) 413-9903
Fax (303) 413-9907

Patient Information Intake
Bold Indicates Required Fields

Last Name: _____ **First Name:** _____ **M.I.:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: H: _____ **( ) *best*** **C:** _____ **( ) *best*** **W:** _____ **( ) *best***

Birthdate: _____ **SSN/Driver's Lic:** _____ **Sex:** _____

E-Mail: _____

Referring Doctor: _____

PCP Doctor: _____

Marital Status: Single Married Other Student Status: Full-time Part-time

Employer: _____ Employment Status: Full-time Part-time Retired

Primary Insurance Information

Insurance Company: _____ **Phone:** _____

Policy Holder: _____ **Relationship to Patient:** _____ **Insured DOB:** _____

Policy #: _____ Group #: _____

Date of Accident/Injury: _____ Work / Auto / Other Adjuster Name: _____ Ext #: _____

Secondary Insurance Information

Insurance Company: _____ **Phone :** _____

Policy Holder: _____ **Relationship to Patient:** _____ **Insured DOB:** _____

Policy #: _____ **Group #:** _____

Office Staff Only

Appt Date: _____ **Time:** _____ **Therapist:** _____

Dx: _____ **Surgical Date:** _____

Dx Codes: _____ _____ _____

Office Policies:

Please initial each allotted space, and sign and date below as acknowledgement of North Boulder Physical Therapy's office policies.

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____ have received the Notice of Privacy Practices from North Boulder Physical Therapy Rehabilitation, LLC.

Initial: _____

In lieu of patient signature, I _____, staff member of North Boulder Physical Therapy, state that, _____, has been given our current Notice of Privacy Practices on _____ (date).

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge **$45.00 for each missed appointment**. Often patients are waiting for appointments on a cancellation list, and the courtesy of your phone call allows us to schedule them. If we are closed please leave a voicemail. This charge is NOT covered or billed to your insurance and is ***due at the time of your next appointment.***

Initial: _____

Supplies and Equipment:

I agree to pay for physical therapy supplies in full on the date of service. I understand that North Boulder Physical Therapy is not considered a durable medical goods provider, and that most insurance companies will not reimburse for supplies such as orthotics, equipment, or any other durable medical good. If my insurance were to cover supplies, I understand that I will only be reimbursed the amount of money paid to North Boulder Physical Therapy by insurance.

Initial: _____

Release of Information:

I **do / do not** (please circle one) authorize _____ (physician's name) to release any of my medical records, x-rays, or reports to North Boulder PT for the purpose of obtaining medical information pertaining to my treatment. I also authorize North Boulder PT to release my medical records to the above named physician.

Initial: _____

Assignment of Benefits:

I hereby assign payment directly to North Boulder Physical Therapy, who represents this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident, and the medical benefits are exhausted such that financial responsibility reverts to my health insurance, I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment.

Initial: _____

Changes in Billing or Health Insurance Information:

I understand it is my responsibility to update, in a timely manner and in writing, North Boulder Physical Therapy of any changes to my insurance coverage or personal information such as address, phone numbers, and name changes.

Initial: _____

Quote of Insurance Benefits:

I understand that a quote of benefits is not a guarantee of payment and that I am responsible for any applicable deductibles or co-pays. I understand that it is my responsibility to verify benefits and whether North Boulder PT is in network with my health insurance. *A quote of benefits is provided by North Boulder PT as a courtesy and North Boulder PT is not responsible for misquoted benefits.*

Initial: _____

Signature: _____ ***Date:***_____

Health History Questionnaire

Last Name: _____ **First Name:** _____ **M.I.:** _____ **DOB:** _____

Date of injury or onset: _____ **Date of surgery:** _____ **Cause of Problem (circle:)**

Motor vehicle Aging
Work Fall
Sport Repetition
Daily life Other

Date of next appointment with referring physician's office: _____

Have you received physical therapy this year? Yes / No **If so, how many visits:** _____

List medications, vitamins, and supplements. Include dosage, frequency, and method (or provide a print out):

1. _____ taken for _____
2. _____ taken for _____
3. _____ taken for _____
4. _____ taken for _____

Please list current medical conditions and any past injuries or surgeries with dates:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you had a recent: : XRay MRI CT Scan Other test: _____

Please select all conditions that apply to you:

___ Heart disease
___ Cancer
___ Stroke / TIA
___ Latex allergy
___ Fibromyalgia
___ Hepatitis A B or C
___ Fatigue/Energy loss
___ Weight loss/Gain
___ Diabetes
___ Asthma/COPD
___ Seizures
___ Broken bones
___ Arthritis
___ HIV/AIDS
___ Headaches
___ Neurological
___ Osteoporosis / Osteopenia
___ High blood pressure
___ Currently may be pregnant
___ Balance issues / dizziness
___ Spine conditions
___ Taking blood thinners
___ Loss of bladder or bowel control
___ Other: _____

Occupation: _____

Work Requirements (check all that apply):

___ Clerical
___ Driving vehicle
___ Air travel
___ Sedentary
___ Light physical
___ Moderate physical
___ Heavy physical
___ Prolonged sitting
___ Repetitions of same movement
___ Other: _____

Daily Activities, Hobbies or interests *which are limited by your present condition*: _____

_____

Exercise or recreational activities *which are limited by present condition:* _____

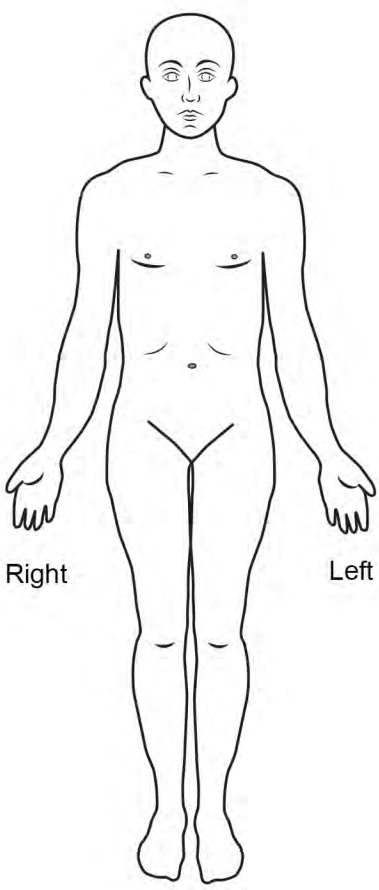
_____

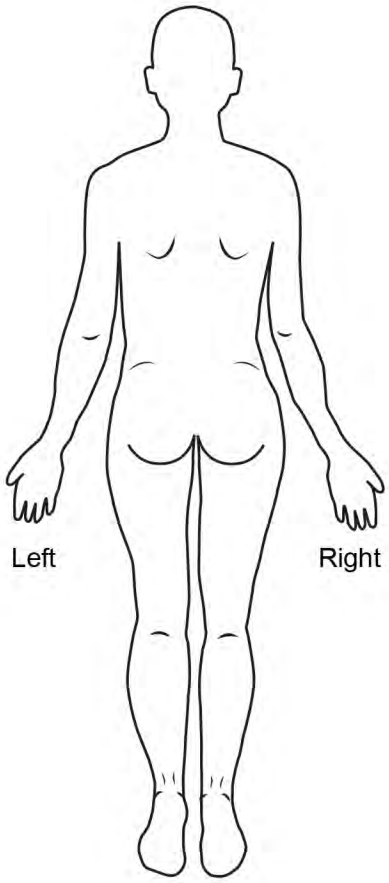
Do you regularly exercise? Describe frequency, duration and type: _____

_____

Health History Questionnaire (cont.)

On the body diagram below, please mark where your symptoms are located at the present time.
Please include a description such as pain, tingling, numbing, burning, aching, or shooting symptoms next to the area(s) marked:





When is the pain the worst?
___ morning
___ evening
___ while sleeping
___ no pattern

Frequency of pain or complaint?
___ never
___ rare
___ occasional
___ often
___ very often
___ constant

Rate your pain from 0 to 10 (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Please list any positions or activities which *decrease* your pain or condition: _____

_____

Please list any positions or activities which *increase* your pain or condition: _____

_____

Other comments or concerns about your health: _____

_____