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: _____

Missed Appointments:

Unless cancelled at least 24 hours in advance, **our policy is to charge $45.00 for each missed appointment**. The courtesy of your phone call allows us to schedule patients on our waitlist. 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 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 PT by insurance.

Initial: _____

Release of Information:

I authorize _____(referring 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 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 Benefits:

I understand that a quote of insurance 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 my 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: _____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

DATE:

Name (Last, First):_____DOB:_____/_____/_____

Occupation:_____

EMERGENCY CONTACT INFORMATION

Primary Contact _____ Phone: ( ) _____-_____

Secondary Contact_____ Phone: ( ) _____-_____

MEDICAL HISTORY

Please check ☑ all conditions that apply to you:

☐Allergies (Specify:_____)	☐Diabetes	☐Gastrointestinal/IBS	☐Stroke/TIA
☐Anemia	☐Dizziness/Vertigo	☐Latex allergy	☐Traumatic brain injury
☐Arthritis	☐Fatigue/Energy loss	☐Multiple Sclerosis	☐Vision/hearing impaired (circle)
☐Asthma/COPD	☐Fibromyalgia	☐Neurological condition	☐Weight loss/gain (circle)
☐Bladder/bowel dysfunction	☐Fracture(s)	☐Osteoporosis/Osteopenia	☐Other:_____
☐Blood clots/thrombosis	☐Headaches	☐Pacemaker/implant	☐Other:_____
☐Cancer (Specify:_____)	☐Hepatitis A B or C	☐Parkinson's Disease	☐Other:_____
☐Cardiovascular disease	☐HIV/AIDs	☐Pregnant or may be pregnant	
☐Depression	☐Hypertension	☐Seizures	

MEDICATIONS

Please list current medications, vitamins and supplements (you may attach list or write on back if you need more room)

	Name	*Dosage/Frequency*	*What do you take this for?*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

SURGICAL HISTORY

Please List Prior Surgeries (you may attach list or write on back if you need more room):

	Surgery Performed	*Date*
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

PHYSICAL THERAPY INTAKE QUESTIONNAIRE

Name:_____**DOB:**_____ /_____ /_____ **Date:**_____

CURRENT CONDITION

What is the injury or condition that brings you in today?

_____

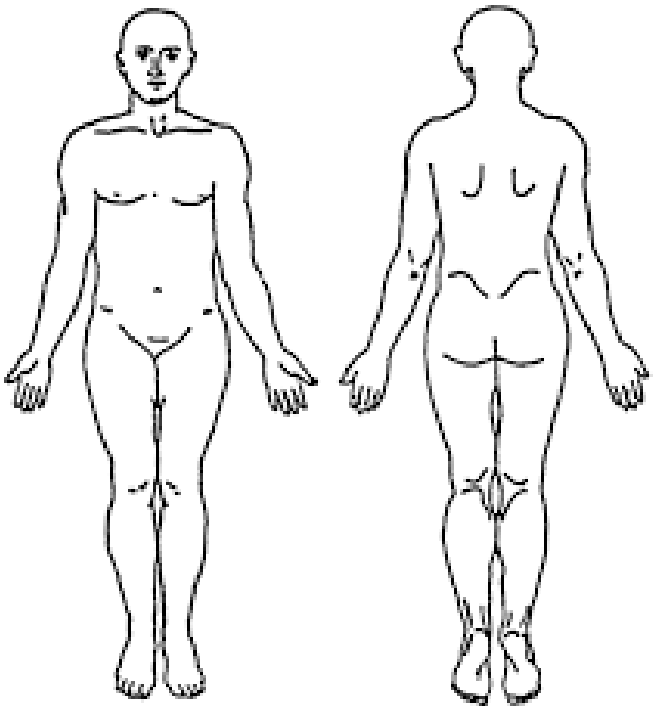
When did the problem start? _____

How did you injure yourself? ☐ Aging ☐ Daily Life ☐Fall ☐Motor Vehicle
☐ Repetition ☐Work injury ☐Other:_____

Did you have surgery? ☐ Yes ☐ No If yes, surgery performed:_____ ___Date: _____

Have you had any recent imaging? ☐XRay ☐ MRI ☐ CT Scan ☐ Other:_____

On the diagram below, please indicate the area where you are experiencing the symptoms for which you are seeking treatment today:



Please circle and indicate the numbers which correspond to your pain at its ***best, worst, and currently:***

BEST	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENTLY	0	1	2	3	4	5	6	7	8	9	10

GOALS

Please list any specific goals, issues or concerns you may have with your physical therapy:

1. _____
2. _____
3. _____