1503 Washington Lane
Augusta, KS 67010
(316) 775-0700
Fax (316) 775-0730

418 N. Andover Rd. Suite 400
Andover, KS 67002
(316) 733-0077
Fax (316) 733-9007

Patient Intake Form

Referring Physician: ______________________ **Work Related Injury? Yes______ No______**

How did you find out about us? ☐**Direct Mail** ☐**Your Physician** ☐**Daily Newspaper**
☐**Shoppers Guide** ☐**Billboard** ☐**Friend – Who?_________________**

In the past 3 months have you had any kind of home health care? Yes ____________ No _____________
(If yes, please notify the front desk at the time of service)

PATIENT INFORMATION

Legal Name: ____
Address: __________________________ City: ________________ State: ____________ Zip: _________
Date of Birth: ___________________ Age: _________________ SSN: _________________
Home Phone: __________________ Cell Phone: _______________ E-mail Address: ________________
Patient Employed By: ____
Business Address: ____
Business Phone: _________________ Occupation: ____________________

SPOUSE INFORMATION OR CARD HOLDER INFORMATION

Legal Name: ______________________ SSN: ________________ DOB: _______________
Telephone Number: ______________________ Address: ___________________________
City: _________________ State: ____________ Zip: ________
☐**Same as my information above**

INSURANCE INFORMATION

Primary Insurance: ____
Secondary Insurance: ____
☐**I do not have medical insurance**

URGENT CARE INFORMATION

Emergency Contact (other than spouse):_______________________Phone Number: _________________________
Address: ____
Relationship to patient: ____

RELEASE AND ASSIGNMENT INFORMATION

Release of Medical Information: I hereby authorize PT Plus to release my medical information and/or statement of charges connected with these services to, but not limited to, an insurance carrier, workman's compensation carrier, health and welfare funds, attorneys, consultants, and anyone assisting in obtaining payment.
Insurance Assignment: I hereby assign medical benefits of any type arising out of any policy of insurance, insuring the patient or any other party liable for the patients care to, PT Plus, Inc., to be applied to the charges for services rendered.
Agreement to Pay for Services: For and in consideration of the care and treatment provided to the patient, I agree to pay PT Plus for all charges for services rendered to or on behalf of the patient, including charges for insurance deductible and co-insurance which are not covered by the insurance carrier, workers compensation carrier, health and welfare funds, and fees or charges by attorneys, consultants, and anyone assisting in obtaining payment.

____ _____________________________
Patient Signature (or legal guardian if under 18 years old) **Date**

1503 Washington Lane
Augusta, KS 67010
(316) 775-0700
Fax (316) 775-0730

418 N. Andover Rd. Suite 400
Andover, KS 67002
(316) 733-0077
Fax (316) 733-9007

MEDICAL HISTORY

Patient Name:_________________________ Date of Birth:_______________ Next Dr Apt___________
Injury / Condition:______________________ Surgery Date:______________ Onset Date:____________
Have you received physical therapy or Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed for this condition? Please mark all that apply:
☐X-Ray ☐CT Scan ☐ MRI ☐Doppler ☐ Ultrasound ☐Bone Scan
What did they show?____

Have you recently noted:
☐Pregnant / IUD ☐Numbness / Tingling ☐Fatigue ☐Change In Vision Or Hearing
☐Nausea /Vomiting ☐Weakness ☐Headaches ☐Fever / Chills / Sweats
☐Pain At Night ☐Weight Loss /Gain ☐Insomnia ☐Cramps In Legs When Walking

Do you have now or have you ever had any of the following?
☐Cancer – Type____________ ☐Loss of Consciousness/Fainting ☐Fractures
☐Heart Problems / Pacemaker ☐Diabetes ☐Blood Pressure Problems
☐Surgeries – list below ☐Motor Vehicle Accident ☐Allergies / Skin Sensitivity
☐Sprains / Strains ☐Seizures ☐Hearing Difficulties
☐Circulation Problems / Clots ☐Asthma / Breathing Problems ☐Lung Disease
☐Easy Bruising / Bleeding ☐Leg / Ankle Swelling ☐Stroke
☐Indigestion / Heartburn ☐Urinary Problems / Infections ☐NONE APPLY TO ME
☐Any other medical conditions: ____

Explain & give approximate dates for any items indicated above _______________________________
____
____
Are you currently taking medications? Yes / No
Attach list - or - Write Name or Type of Medication:
____
____

Current Pain Description
Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other: ___________________________
Rate your pain (average) on a 1-10 scale (1=minimal 10=severe) Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Treatment Goals
What do you hope to get out of your treatment? ____
____
Is there anything else you would like to include or ask your physical therapist? _____________________
____

______________________________ ________________
Patient Signature **Date**

1503 Washington Lane
Augusta, KS 67010
(316) 775-0700
Fax (316) 775-0730

418 N. Andover Rd. Suite 400
Andover, KS 67002
(316) 733-0077
Fax (316) 733-9007

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment **we require a 24 hours notice.** In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $20 cancellation fee.

If you are non-compliant with two of your scheduled visits we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Sincerely,

PT Plus Staff

I have read and understand this policy: ___________________________________Date: ___________

1503 Washington Lane
Augusta, KS 67010
(316) 775-0700
Fax (316) 775-0730

418 N. Andover Rd. Suite 400
Andover, KS 67002
(316) 733-0077
Fax (316) 733-9007

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

AT PT PLUS WE PRIDE OURSELVES ON PROVIDING GREAT SERVICE. AS PART OF OUR SERVICE, WE COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPPA) ACT OF 1996. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GETACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request. Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I have been given the Notice of Privacy Practices from PT Plus, Inc. I have read and understand these practices.

____ ____________

Patient or Personal Representative Signature **Date**