Southwest Orthopaedic Physical Therapy

Hello

Thank you for accessing the intake form we have created for our new patients. Please fill out this form and FAX or bring it to our clinic @ 1334 Wyoming Blvd. NE. This will expedite the registration process on your first visit.

Please call our office if you have any questions: (505) 292-3317

Our fax number is (505) 292-3402.

We appreciate you choosing Southwest Orthopaedic Physical Therapy (SWOPT) and we look forward to caring for your orthopedic physical therapy needs.

Sincerely

*The "SWOPT" Team*

Today's Date: _____

Practitioner _____

| Initial Eval Date: | | |
|---|---|---|
| Rescheduled Appt. 1: | | |
| Rescheduled Appt. 2: | | |

## PATIENT INFORMATION

| Patient Name: | Gender: | DOB: | Social Security: |
|---|---|---|---|
| | | | |

| Address: | City: | State: | Zip: | Email |
|---|---|---|---|---|
| | | | | |

| Home Phone : | Work Ph | Cell | Employer Name: | Occupation: |
|---|---|---|---|---|
| | | | | |

| Date of Injury or Onset: | Chief Complaint/Body Part: | ICD-9 Code: | Rx Date: (required) |
|---|---|---|---|
| | | | |
| | PT Diagnosis | | |
| | | | |

## PRIMARY INSURANCE INFORMATION

| Primary Insurance Company Name: | Policy/Claim or ID : | Group (required for all HMO's) |
|---|---|---|
| | | |

| Name of person who holds policy: | Relation to patient: | Phone : | Fax : (if W/C) |
|---|---|---|---|
| | | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| DOB/SSN of Card Holder | |
|---|---|
| | |

## INSURANCE VERIFICATION INFORMATION

| Contract/Adjustor Name | | Deductible Amt | | | Co-Insurance Amt: | | Insurance Pay Prct: |
|---|---|---|---|---|---|---|---|
| | | Effective Date: | | | Avg.: | | |
| Authorization | | No of visits apprv'd | | Auth. Dates | From: | | Copay Amt: |
| Verbal Approval: | | | | | To: | | |

## SECONDARY INSURANCE INFORMATION

| Secondary Insurance Company Name: | Policy/Claim or ID | Group (required for all HMO's) |
|---|---|---|
| | | |

| Name of person who holds policy: | Relation to patient: | Phone | Fax : (if W/C) |
|---|---|---|---|
| | | | |

## ATTORNEY INFORMATION

| Attorney Name | Email | Phone | Fax |
|---|---|---|---|
| | | | |

| Address: |
|---|
| |

| Physician's First and Last Name: | | Phone | | |
|---|---|---|---|---|
| UPIN (req'd if new dr.) | | Fax: | | |

| Address: | City | State | Zip | Email |
|---|---|---|---|---|
| | | | | |

PATIENT NAME:_____ DATE:_____

Are you presently working? Yes_____ No_____ Date of next physician's visit_____

1. Date of injury/onset_____
2. Have you ever had these symptoms before? Yes_____ No_____
3. Check which apply to your symptoms:

_____ work related injury
_____ motor vehicle accident
_____ cause unknown
_____ other:_____
_____ recurrence of previous injury
_____ injury related to lifting
_____ athletic/recreational injury

4. Have you had a related surgery? Yes_____ No_____
5. Do you have, or have you had any of the following:

| | | | |
|---|---|---|---|
| Diabetes | _____yes _____no | Allergies to Aspirin | _____yes _____no |
| Chest Pain/Angina | _____yes _____no | Allergies to Heat | _____yes _____no |
| High Blood Pressure | _____yes _____no | Allergies/Poor Tolerance to Cold | _____yes _____no |
| Heart Disease | _____yes _____no | Other Allergies | _____yes _____no |
| Heart Attack | _____yes _____no | Hernia | _____yes _____no |
| Heart Palpitations | _____yes _____no | Seizures | _____yes _____no |
| Pacemaker | _____yes _____no | Metal Implants | _____yes _____no |
| Headaches | _____yes _____no | Dizziness/Fainting | _____yes _____no |
| Kidney Problems | _____yes _____no | Recent Fractures | _____yes _____no |
| Are you pregnant? | _____yes _____no | Surgeries | _____yes _____no |
| Cancer | _____yes _____no | Skin Abnormalities | _____yes _____no |
| Bowel/Bladder Abnormalities | _____yes _____no | Sexual Dysfunction | _____yes _____no |
| Asthma/Breathing Difficulties | _____yes _____no | Nausea/Vomiting | _____yes _____no |
| Liver/Gallbladder Problems | _____yes _____no | Ringing in your ears | _____yes _____no |
| Other | _____yes _____no | Rheumatoid Arthritis | _____yes _____no |
| Smoking | _____yes _____no | Special Diet Guidelines | _____yes _____no |

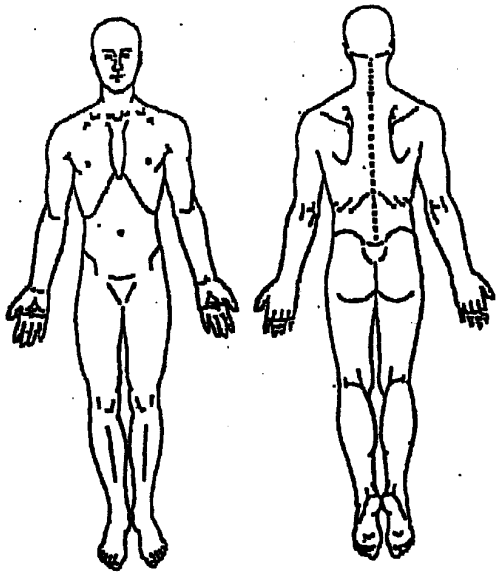
If yes on any of the above, please briefly explain and give approximated date:_____

Is there any other information regarding your past medical history that we should know about?_____

6. Are you presently taking medication? _____Yes _____No;
If yes, please list what medication and for what condition:

7. Rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible:_____

10. Please indicate below where your pain is located.



8. In the rare instance of an emergency who should we contact? _____ _____
Name Phone Number

9. Do you participate in any sports, exercise programs, or activities on a regular basis? _____Yes _____No

_____ _____ _____
Signature Relationship to Patient Date

Patient Name _____ Date _____

*Although it is rare, we occasionally need additional contact information for emergency, medical, insurance, or billing/collection purposes. Please provide the following information:*

**Account Responsible information:**

| | | |
|---|---|---|
| Name:<br>_____ | Address:<br>_____<br>_____<br>City State Zip | Phone number:<br>(___)_____ |
| Relationship to patient<br>_____ | Date of birth_____ss#_____ | |
| If you are 17 years of age or older are you a full time student? _____yes_____no | If you are full time student older than 18yrs old – Where are you a student?<br>_____ | |

**Emergency or additional contact information**:

| | | |
|---|---|---|
| Name<br>_____ | Phone number:<br>(____)_____ | |
| Relationship to patient:<br>_____ | | |

**Primary MD:**

| | | |
|---|---|---|
| **Name:**<br>**_____** | **Phone number:**<br>**(___)_____** | |

**Employer information**

| | | |
|---|---|---|
| Name of business_____ | Address<br>_____<br>_____<br>City State Zip | Phone number<br>_____ |
| Are you or the account responsible insured through your place of employment?<br>_____yes____no___ | | |

**SOUTHWEST ORTHOPAEDIC PHYSICAL THERAPY (SWOPT)**

**Consent to treat**

I hereby give written consent to be treated at SWOPT by a licensed physical or occupational therapist, physical therapy student, physical therapy assistant, pt tech or aide, massage therapist, and or myofascial trigger point therapist. _____**initials**

**Are you seeking treatment at this facility for an auto or work related injury? Yes_____no_____**

**If work related please provide the following information:**

Employer name_____
Employer address_____
Employer phone #_____
Adjustor name _____phone #_____
Accident date or date of injury_____
State where accident or injury occurred_____
Claim #_____

**If auto accident or personal injury related please provide the following information:**

Do you want us to bill your primary health insurance company?
Yes_____no_____
Do you want us to bill your auto insurance company?
Yes_____no_____

**Please provide the correct insurance information for billing purposes.**
***we do no accept third party insurance. Patient will be billed for all charges in full and if insurance pays and later recoups payment due to 3rd party liability, patient will still be responsible for full charges.**

**I understand that insurance may or may not cover some or all the services provided and the treatments I receive. I understand that I will be ultimately responsible for any balances on my account.**

_____ **initials**

**If an attorney is hired at any point during treatment I understand I must notify this office immediately and provide a letter of protection from my attorney**

_____ **initials**

Attorney name_____
Attorney address_____
Attorney phone number_____

**Authorization to release medical information**

I hereby authorize the release of my medical and billing records to any healthcare provider involved in my care and treatment. SWOPT may also release information to any person or organization liable for all or part of my charges, such as my insurance carrier, my adjuster, my insurance claim department, any 3rd party payor, medicare/medicaid, my employers workers compensation carrier, my attorney. I acknowledge that upon the disclosure of medical record information to an insurance company or payor pursuant to this authorization, SWOPT is no longer responsible for the confidentiality of any information know or possessed by the payor.

_____**initials**

**HIPPA**

I have been provided a copy of the hipaa policy to review. I have read and understood my rights under HIPPA A personal copy of the HIPPA agreement will be provided for my records upon request.

_____**initials**

**I have read and understand the above information.**
**Patient/guardian signature_____date____**

**SOUTHWEST ORTHOPAEDIC PHYSICAL THERAPY FINANCIAL POLICY**

As a courtesy to our patients, insurance claims (primary and secondary) are filed directly with the insurance carriers. Our office will normally assist you by contacting and verifying your eligibility for medical benefits. Verification of eligibility and benefits **does not** guarantee payment for all services provided. Ultimately you are responsible for knowing/understanding your benefits, policy coverage, limitations, and exclusions and for paying the balance on your account. Our office will **NOT** be responsible for incorrect information passed on to us by the insurance company. You are responsible for all out-of-pocket expenses (co-pays, co-insurance, deductibles, no show fees and any non covered services that have been provided) We will estimate the co-insurance percentages based on what we expect the insurance company to pay. Because this is an estimate and not an exact figure, there is a possibility that you will still be responsible for an additional balance and or that you may be due a credit refund if you have overpaid.

**Any change in your insurance status must be reported to our office immediately, or denial of payment may result. This may result in balance becoming your financial responsibility**.

For patients with secondary insurance, we will file as a courtesy; however, Southwest Orthopaedic Physical Therapy is bound by the primary insurance contract and follows the rules of said contract to collect all co-pays, co-insurances, deductibles at time of service. If the secondary payor pays additional funds, we will refund monies due to patient. If the secondary payor states that there are additional monies to be paid to SWOPT, the patient is still responsible for all co-pays, co-insurance, deductible and any non covered services as directed by the primary payor (with the exception of Medicaid as secondary payor). If we have not received payment from secondary insurance within 90 days, the balance may be transferred to patient responsibility and it will be up to you to pursue payment from your insurance company.

**A $25 no show/cancellation fee** will be charged to your account if you fail to provide 24 hours notice. Circumstances may arise that would not allow you to provide the 24 hour notice. In this case, please contact our office as soon as possible. We reserve the right to cancel all future appointments after 3 missed appointments.
I understand that I am financially responsible to pay my NO show/cancel fees _____**Initials**

**ASSIGNMENT OF INSURANCE BENEFITS** I authorize my insurance company to make payment to Southwest Orthopaedic Physical therapy for services rendered to me or my insured dependent.
_____**Initials**If
Medicare is filed, I authorize the release of any medical information or other information necessary to process claim. I also request payment of government benefits either to myself or to the party who accepts payment. _____**Initials**
I agree to notify this office of any changes in my insurance status or the information given this date. I understand that failure to provide updated information may result in denial of payment and will become my financial responsibility. _____**Initials**
I understand that obtaining prior authorization and verification of eligibility and benefits does not guarantee payment and that I am ultimately responsible for all out of pocket expenses which may include but are not limited to co-pays, coinsurance, deductibles, non covered services, no show fees, and that balances are due at time of service. _____**Initials**
I understand that even if I have secondary insurance, I may still be responsible for balances due as dictated by primary insurance if secondary insurance does not pay (Medicaid is the exception)
_____**Initials**
********** I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING SWOPTS FINANCIAL POLICY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCES DUE ON MY ACCOUNT.
**PATIENT/GUARDIAN SIGNATURE** _____**DATE**_____

**SOUTHWEST ORTHOPAEDIC PHYSICAL THERAPY (SWOPT)**
PAYMENT POLICY

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I understand that it is the policy of Southwest Orthopaedic Physical Therapy to collect the balance on my account on each date of service. This balance may be due to but is not limited to co-pay/co-insurance, deductible or non-covered services. SWOPT will estimate the co-insurance percentages based on what insurance is expected to pay. Because this is an estimate and not an exact figure, there is a possibility that I will still be responsible for an additional balance and or that I may be due a credit refund if I have overpaid. **_____Initials**

I understand that quotes of eligibility and benefits does not guarantee payment from my insurance company for all or part of the services I receive and I am ultimately responsible for balances due on my account. **_____Initials**

**\*PLEASE REVIEW THE EXPLANATION OF BENEFITS YOU RECEIVE FROM YOUR INSURANCE COMPANY AND NOTE WHAT SERVICES ARE COVERED OR NON - COVERED AND WHAT YOUR INSURANCE SAYS IS PATIENT RESPONSIBILITY. MANY TIMES SOME SERVICES ARE NOT COVERED AND YOU ARE RESPONSIBLE FOR THOSE AMOUNTS IN ADDITION TO YOUR COINSURANCE OR CO-PAYMENTS. OFTENTIMES PATIENT WILL RECEIVE INSURANCE STATEMENT BEFORE SWOPT DOES SO THIS SHOULD PROVIDE YOU TIME TO DECIDE IF YOU WOULD LIKE TO CONTINUE RECEIVING NON COVERED SERVICES. IF NOT IT IS YOUR REPSONSIBILITY TO NOTIFY YOUR THERAPIST SERVICES ARE NOT BEING COVERED AND DISCUSS OTHER TREATMENT OPTIONS.**

If I am unable to pay my entire balance due on each day of service I agree to pay 50% or greater of my balance as a deposit toward my total out-of-pocket responsibility. **_____Initials**

If unable to pay my balance at time of service, my future appointments may be cancelled or rescheduled after the 3rd unpaid appointment, unless a payment plan is arranged with the billing office department. **_____Initials**

I understand that I will also be billed for any outstanding balance, until my account is paid in full. **_____Initials**

**Patient/guardian signature_____Date_____**

## Consent for Photography/Videotaping for publicity and or publicity and Marketing

Patient's Name: _____

I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member and/or consent to interviews with a member of the SWOPT staff. I understand and agree that these images may be used by the news media ( in the case of a press release) or by SWOPT for the purpose outlined below: Documentation, marketing, publicity, advertising, website, social media marketing, and patient progress.

Signature of Patient or Legal Representative Date Signature of Witness Date
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