PATIENT INTAKE FORMS

Name: (Last) ______________________________ (First) __________________________ (Middle) ___________

Home Address: ____

City: ____ State: __________ Zip Code: __________________

Mailing Address: (if different) ____

Primary Phone: _______________________________ Secondary Phone: _________________________________

Circle one: cell | home | work Circle one: cell | home | work

Email: ____

Date of Birth: ___________________ Age: ________ Social Security Number: _____________________________

Emergency Contact: ____ Phone: _________________________

How did you find out about us?

- ☐ Doctor Referral
- ☐ Family/Friend
- ☐ Google
- ☐ Facebook
- ☐ Yelp
- ☐ Other (please specify): ____

As a courtesy, appointment reminders are sent the business day before your next appointment.

- ☐ I want a reminder call/ text.
- ☐ I DO NOT want a reminder call/ text.

APPOINTMENT CANCELLATION/ NO SHOW POLICY

Thank you for trusting your physical therapy care to SB Physio. When you schedule an appointment with SB Physio, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, **no later than 24 hours prior to your scheduled appointment**. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellations/No Show Policy below:

- Any established patient who fails to attend or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "No Show" and charged a **$50.00 fee**.
- We reserve the right to withhold further treatment of any patient who has **accrued 2 No Show charges** until their account has been balanced.
- If a **third** No Show or cancellation/reschedule with no 24- hour notice should occur, the patient may be **dismissed** from SB Physio.
- Any new patient who fails to attend for their initial visit **twice** will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager. You may contact SB Physio 24 hours a day, 7 days a week, at the number below. If you are calling after regular business hours Monday through Friday, or a weekend, you may leave a message.

SB Physio (805) 682-2536

I have read and understand the Appointment Cancellation/ No Show Policy and agree to its terms.

______________________________	______________________________
Signature (Parent/Legal Guardian)	Relationship to Patient
______________________________	______________________________
Patient Name	Date

FINANCIAL POLICY: You are responsible for your bill. We bill your personal insurance carrier solely as a courtesy to you. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If formal collections procedures become necessary you will be responsible for additional costs incurred. The attached benefits information is not all-inclusive. It is limited to coverage limitations, terms of your contract with your insurance, terms of any direct or indirect contract we hold with the payer, and your specific insurance plan's interpretation of the medical necessity of the services provided. Please refer to your insurance plan's applicable benefit agreements to determine any limitations or exclusions for your rehabilitation services. Furthermore, I understand that I cannot change my payment option after services have been rendered.

CHOOSE AND INITIAL ONE-

♦ I understand that SB Physio will bill my **insurance company**, but that it is ultimately my responsibility to know the extent of my insurance benefits. ____________ (please initial)

♦ I choose to **self-pay at the cash rate**. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment. ___________ (please initial)

♦ I understand that SB Physio will bill my **workers' compensation company** and that my treatment must not exceed what they have authorized. ___________ (please initial)

HIPAA COMPLIANCE: I understand that SB Physio, may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that SB Physio will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my PHI for purposes as noted in SB Physio's Notice of Privacy Practices, which is displayed in the reception area and a copy of which is available upon request. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for SB Physio- A Physical Therapy Corp. to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize SB Physio- A Physical Therapy Corp to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

CO-PAYMENTS: Co-payments are due at the time of service.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be subject to a $25 processing fee.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 25 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ ________________

PATIENT/GUARDIAN SIGNATURE DATE

____

PRINTED NAME

MEDICAL SCREENING FORM

Date of Birth: ________________________ Age: __________ Height: ___________ Weight: ____________

Gender: Male ☐ Female ☐

Occupation: ______________________________ Currently working? Yes ☐ No ☐

Please describe your current symptoms: ____

____

When did symptoms start? ____

How did symptoms start? ____

____

My symptoms are currently: ☐ Getting Better ☐ About the same ☐ Getting Worse

Please list any previous treatments for the condition we are seeing you for today:

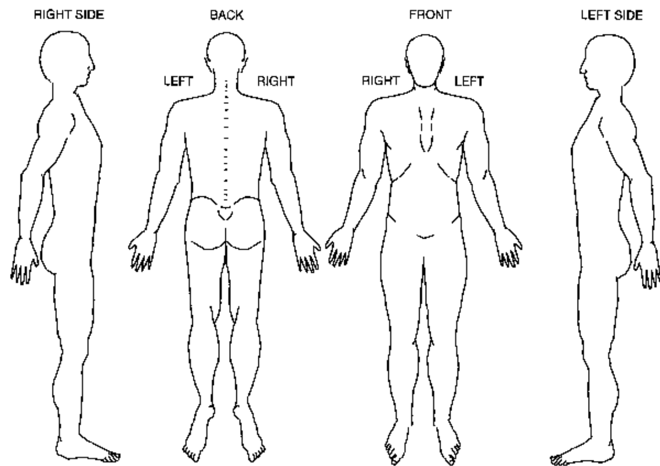
____

Have you fallen in the past 12 months? Yes ☐ No ☐

If so, how many times? ____________

Have you had imaging studies done for this problem (x-rays, MRI, etc)? ☐ Yes ☐ No

Please use these symbols to note symptoms location: ^^ Numbness ** Pins & Needles // Pain



Circle the number that represents your *average* level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Circle the number that best represents your *worst* level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please list any allergies: ____

Please list any other current medical conditions: ______________________________________

____

Please provide a list of current medications:

____

____