



## Welcome to Marysville Physical Therapy!

We're happy you have chosen us to provide your outpatient physical therapy. We are committed to helping you meet your personal health goals through physical therapy via a customized clinical process as well as to educate you on your condition to help you prevent recurrence.

### What to Expect:

As part of your orientation, your first visit will consist of a complete Physical Therapy evaluation. We will discuss your physical history, current condition and perform a complete physical examination. The physical examination will consist of specialized tests designed to assess your body mechanics as well as your strengths and weaknesses. This will enable our therapists to develop an individualized program specifically designed to treat your diagnosis limitations.

You will be asked to complete periodic evaluation forms so that we can accurately assess your progress, and we will provide your doctor with a report of your progress.

### What to Wear:

Be prepared to move around a lot during your first physical therapy session. With that in mind, we recommend that you wear loose-fitting clothing and sneakers for maximum comfort.

**Please complete the attached forms and bring them to your initial appointment.**

### Please also bring the following:

- Your referral or prescription from your doctor for physical therapy
- Your driver's license or other photo ID.
- Your insurance card(s)

### Appointments:

- Please be sure to arrive at least 15 minutes prior to your initial evaluation to complete intake paperwork.
- It is important to the recovery process that you keep all your prescribed appointments. Should you need to cancel, kindly notify our office **at least 24 hours** in advance.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all our clients and you may be asked to reschedule your appointment if you arrive more than 10 minutes late.

If you have any questions or need to change the date or time of your appointment, please call our office and we will be happy to make the adjustment for you.

Thank you for choosing Marysville Physical Therapy; we look forward to working with you!



**Patient Intake Form**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
(last) (first) (MI)

**Mailing Address:** \_\_\_\_\_  
(number and street) (city) (state) (zip)

**Cell #** (\_\_\_\_) \_\_\_\_\_ **Home #** (\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone #** (\_\_\_\_) \_\_\_\_\_

**Relationship of Emergency Contact:** \_\_\_\_\_

**What is your reason for seeing us (circle one)?** Auto Injury Work Injury Surgery Other

**Referring Physician:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Are you currently receiving home health, or have you received it in the past 60 days?** YES / NO

If yes, please provide the name of the home health agency. \_\_\_\_\_

**Have you recently been discharged from home health?** YES / NO

If yes, what was the date of your last home health visit? \_\_\_\_\_

\_\_\_\_\_ **Please initial to acknowledge that if at any point during your treatment at this facility you start to receive home health services (or other Medicare Part A services), you will notify this facility immediately.**

**Authorization & Consent**

- I understand that I am responsible for all charges incurred regardless of insurance or third-party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize **Marysville Physical Therapy** to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3<sup>rd</sup> party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to **Marysville PT.**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

## Patient History Form

**Note:** This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**Date of Birth** \_\_\_ / \_\_\_ / \_\_\_ **BMI:** Height \_\_\_\_\_ Weight \_\_\_\_\_

**Today's Date** \_\_\_ / \_\_\_ / \_\_\_ **Date of last Physician exam** \_\_\_ / \_\_\_ / \_\_\_

### History of Present Problem

**What is the main reason for your evaluation today?**

\_\_\_\_\_

\_\_\_\_\_

**Have you had surgery related to this condition?** \_\_\_ YES \_\_\_ NO

If yes, type of surgery: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

**On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable)**

**circle the number that best describes your average pain.** 0 1 2 3 4 5 6 7 8 9 10

**When did you first notice the problem? (circle)**

days ago    weeks ago    months ago    years ago

Other \_\_\_\_\_

**Please mark the location of the pain on the diagram below.**

**Problem worsens with: (circle all that apply)**

Movement    Inactivity    Standing    Lying    Sittin

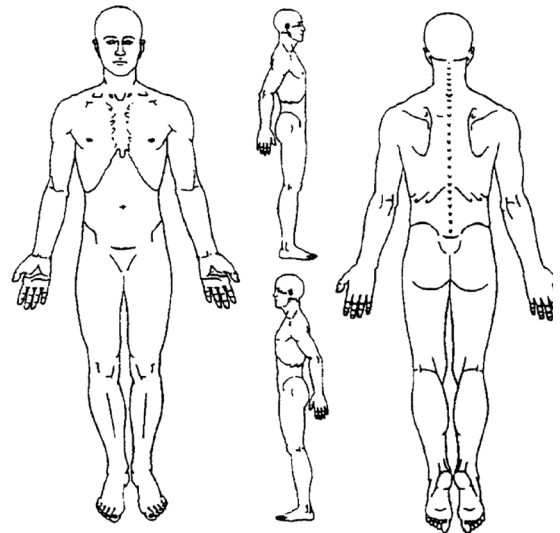
Other \_\_\_\_\_

**Problem improves with: (circle all that apply)**

Movement    Inactivity    Standing    Lying    Sittin

Rest    Medication    Heat    Ice

Other \_\_\_\_\_



**How frequently are you bothered by this problem? (circle one)**

Constant    Occasional/Variable

Other \_\_\_\_\_

**How would you describe the problem? (circle one)**

Dull    Sharp    Dull then Sharp    Very sharp then stops

Other \_\_\_\_\_

**Do you have any other symptoms?**

NO    YES (please explain): \_\_\_\_\_

**Does the problem interfere with daily functions?**

NO    YES (please explain): \_\_\_\_\_



## Medical History

*Do you now or have you ever had (please check all that apply):*

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> High Cholesterol  |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Hypothyroidism  |
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Incontinence  |
| <input type="checkbox"/> Anxiety/Panic Disorders   | <input type="checkbox"/> Jaundice  |
| <input type="checkbox"/> Arthritis (rheumatoid/osteoarthritis)                                     | <input type="checkbox"/> Joint Pain/Swelling   |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Kidney/Bladder/Prostate/Urination Problems                  |
| <input type="checkbox"/> Back Pain (neck pain/back pain/degenerative disc disease/spinal stenosis) | <input type="checkbox"/> Multiple Sclerosis / Parkinson's/ Any Neurological Disease  |
| <input type="checkbox"/> Cancer (Type: _____)  | <input type="checkbox"/> Leukemia  |
| <input type="checkbox"/> CHF/Any Heart Disease/Heart Murmur  | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Chronic Headaches   | <input type="checkbox"/> Other Disorders   |
| <input type="checkbox"/> Colitis   | <input type="checkbox"/> Paralysis   |
| <input type="checkbox"/> Convulsion  | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> COPD/ARDS/Emphysema   | <input type="checkbox"/> Pneumonia   |
| <input type="checkbox"/> Crohn's Disease   | <input type="checkbox"/> Previous Accidents  |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Prior Surgery   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Prosthesis/Implants   |
| <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Fractures   | <input type="checkbox"/> Pulmonary Embolism  |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer/hernia/reflux/bowel/liver/gallbladder)    | <input type="checkbox"/> Visual Impairment (cataracts/glaucoma/macular degeneration) |
| <input type="checkbox"/> Goiter  | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Sleep Dysfunction   |
| <input type="checkbox"/> Hearing Impairment/Hearing Aids   | <input type="checkbox"/> Stomach or Peptic Ulcer                                     |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Stroke/TIA  |
| <input type="checkbox"/> Hepatitis/AIDS/HIV  | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> PVD (Peripheral Vascular Disease)                           |

**Do you wear dentures?** YES / NO

**Do you wear glasses/contacts?** YES / NO

**Do you have a pacemaker?** YES / NO

**Do you have any skin allergies?** YES / NO

**Have you experienced any falls in the last 12 months?** YES / NO **If yes, how many?** \_\_\_\_\_

**Have you been injured from a fall during the last 12 months?** YES / NO

**Do you have any discomfort/shortness of breath/pain with exercise?** YES / NO

**Do you smoke?** YES / NO **If yes, how much do you smoke?** \_\_\_\_\_

**If you quit smoking, when did you quit?** \_\_\_\_\_

**Is there a chance that you may be pregnant at this time?** YES / NO

**List any allergies to medication:** \_\_\_\_\_

**List any hospitalizations/reasons/dates:**

\_\_\_\_\_



## **Financial Policy & Consent to Treat**

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to the outpatient clinic where you are receiving treatment (the "Clinic").

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

**Collection Policy:** If you allow your patient balance to go 120 days without making payment arrangements, you will be sent to a collection agency. If your balance is sent to collections, you will also be responsible for a \$70 fee in addition to your balance.

### **Payment options if you have insurance:**

1. If you have a deductible to meet, you choose to pay by check or credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for any additional patient responsibility, if any, which is determined by your carrier.
2. You choose to pay your co-payment, determined by your insurance carrier, by check or credit card at the time services are rendered. If there is a balance on your account at the end of the month, we will bill you accordingly.
3. **Payments:** Unless other arrangements are approved, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month. If extenuating circumstances should arise, you can discuss a payment plan with our Billing Department **866-496-8541** or [billing@lincolnrs.com](mailto:billing@lincolnrs.com).

### **Acknowledgment and Consent:**

I, the undersigned, do hereby agree and give my consent for the Clinic to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating physical and mental conditions.

I acknowledge I have reviewed this financial policy and agree to pay for all services that are received. I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. **I acknowledge the clinic will store my credit card information and authorize the clinic to charge my credit card on file for amounts past due and determined to be the patient responsibility.** This authorization will remain in effect until revoked by me in writing.

---

**Signature**

---

**Date**



## **Insurance & Fee Notice**

**Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility. Our billing company will verify your benefits with your insurance company and determine if a preauthorization is required.

**Non-contracted Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your coverage eligibility. You agree to pay any portion of the charges not covered by insurance.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

**Returned Checks:** There is a \$25 fee for any checks returned by your bank.

**Missed Appointments:** If you find that you cannot keep your scheduled appointment, we ask that you cancel at least 24 hours in advance. **Failure to cancel with at least 24 hours' notice or "no shows" will result in a cancellation fee of \$50.00 per appointment.** This charge must be paid in full before receiving further treatment.

**Workers Compensation:** We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

**Motor Vehicle Accidents:** If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

---

Patient Name (please print)

---

Parent or Authorized Representative (if applicable)

---

**Signature**

---

**Date**



## **HIPAA Notice of Privacy Practices**

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

### **Uses and Disclosure of Health Information:**

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

### **Uses and Disclosures Based on Your Authorization:**

Except as stated below, we will not use or disclose your health information without your written authorization.

### **Uses and Disclosures Not Requiring your Authorization:**

In the following circumstances, we may disclose your health information without your written authorization:

- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

### **Patient Rights:**

As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

**Please contact us with any questions, concerns, or complaints regarding our privacy practices.**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



## **Release and Waiver of Liability**

I have been informed of and understand all risks associated with being at this clinic and receiving and engaging in therapy services, including any activities, initiatives, and the use of therapy equipment. In consideration for these services and activities rendered or to be rendered, to the fullest extent permitted by law, I assume full responsibility for any risk of bodily injury, death, or property damage or loss due to any cause, whether related to the clinic, the premises, staff, training, services, activity, equipment, third parties, or anything else, except due to the clinic's intentional misconduct. I understand and agree that I, for myself and my heirs, executors, administrators, and assigns, am releasing the clinic, including its officers, directors, employees, independent contractors, agents, and representatives, from all claims and liability of any kind, including for its or their own negligence or inaction and from other sources or causes of harm, death, injury or loss, that occur at any time to the fullest extent permitted by law, but not for the clinic's intentional misconduct.

I have read and understand this assumption of risk and release agreement. I have had the opportunity to ask all questions about the contemplated activities, therapists, and facilities. By signing below, I agree to these terms and willingly and without duress sign it, on behalf of myself and my spouse/partner/heirs with each's consent and approval, and agree to be bound by it.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## **How Did You Hear About Us?**

***Please place a check mark next to one of the below***

Physician \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Repeat Patient \_\_\_\_\_

Friend/Family \_\_\_\_\_

Name of Friend/Family Member: \_\_\_\_\_

Google/Search Engine \_\_\_\_\_

Website \_\_\_\_\_

Social Media \_\_\_\_\_

Advertisement \_\_\_\_\_

Event \_\_\_\_\_

Other \_\_\_\_\_



**Medical Records Individuals Authorization Form**

I hereby authorize **Marysville Physical Therapy** to release any protected health information (PHI) regarding my treatment, payment or any administrative operations related to my treatment and payment to the below individuals.

If you do NOT wish to share your PHI with anyone, please write "**NONE**", sign, and date.

\_\_\_\_\_  
**First and Last Name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**First and Last Name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**First and Last Name**

\_\_\_\_\_  
**Relationship to Patient**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_