CORE Physical Therapy
1255 S State St, Suite 7
Dover, DE 19901-6932
Phone: (302) 734-0100
Fax: (302) 734-0101

CORE|PT

New Patient Intake Package

- Welcome Letter
- Consent Form
- Appointment Contact Preference
- Medical History
- Current Episode Summary
- Medication List

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Welcome to CORE Physical Therapy.

The purpose of this letter is to provide you with some helpful information to prepare you for your first and subsequent visits to the facility.

Prior to your evaluation being scheduled, your primary insurance will be verified and if necessary authorization obtained. If there is secondary insurance, that also will require verification and authorization. It is suggested that you call the Member Service department at your insurance company and verify what your responsibilities may be regarding copays, deductibles, referrals, etc. Please remember that benefits quoted are not a guarantee of payment per your insurance.

The scheduler will call to schedule evaluation and subsequent session. At that time you should have a prescription from your physician to evaluate and treat unless not required by your insurance company. Any questions regarding the scheduling of evaluations should be directed to the scheduler at **(302) 734-0100.**

When you arrive for the evaluation please come to the Reception Desk in the Outpatient area and have with you:

1. **The script from your physician for evaluation and treatment.**
2. **Your insurance card.**
3. **Any copays or referrals as required by your insurance company.**
4. **Copy of driver's license of the parent or legal guardian.**

Please have all of the above items with you when you arrive or it will be necessary to reschedule your appointment.

After the evaluation has been completed, the therapist will discuss with you a treatment program. If you have any questions or I can be of any assistance to you please call us at **(302) 734-0100**. We look forward to seeing you.

Sincerely,

MMSc, PT, ATC, SCS Robert Dunn, PT, DPT

The Staff of CORE Physical Therapy

CONSENT FORM/RELEASE OF INFORMATION

Patient Name _____

CONSENT TO EVALUATION AND TREATMENT

I do hereby consent to the evaluation and treatment by CORE Physical Therapy. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION

I authorize CORE Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my (Doctor) and (Insurance Company) for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis.

PRIVACY PRACTICES

I acknowledge receipt of the CORE Physical Therapy Notice of Privacy Practice, which I have received at the time of this admission or previously.

ASSIGNMENT OF BENEFITS

I request that payment of the Medicare/Other Insurance benefits be made on my behalf to CORE Physical Therapy for any services furnished to me by CORE Physical Therapy. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of CORE Physical Therapy. CORE Physical Therapy will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

CANCELLATION POLICY

The undersigned is aware and agrees, whether signing as an agent or patient, to an out of pocket fee of $20 dollars for each scheduled appointment that is either missed without notice, or cancelled without 24 hour notice. CORE Physical Therapy requires a 24 hour notice for cancelled appointments. If you cannot keep your appointments because of and emergency or illness we understand. Excessive cancellation or no-show may result in patient discharge from physical therapy services.

Medicare Patients: I understand that if I do not have supplemental insurances, I will be responsible for the co-insurance portion not paid by Medicare as well as any deductible.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness Date Date

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Appointment Reminder Consent

Complete this form and sign below to give your permission for CORE Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

❍ CORE Physical Therapy may send email messages to confirm my upcoming appointments to

_____

❍ CORE Physical Therapy may send cell phone text messages to confirm my upcoming appointments to

_____

I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

❍ ALLTel
❍ AT&T
❍ Boost Mobile
❍ Cingular
❍ Cricket Wireless
❍ Metrocall
❍ MetroPCS
❍ Nextel
❍ Qwest
❍ Sprint PCS
❍ T Mobile
❍ US Cellular
❍ Verizon
❍ Virgin Mobile

_____ _____

Signature of Patient or Guardian Date

PATIENT INFORMATION FORM

CORE|PT

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

General Information

1. If applicable, what is the date of next visit with your referring physician: _____/_____/20_____
2. Have you had surgery related to this injury / symptom onset? ☐No ☐Yes

   If yes, when was it? _____/_____/20_____
3. Are you presently working? ☐No ☐Yes
4. Do you have a Primary Care Physician / Family Doctor? ☐No ☐Yes

   If yes, have you had an appointment with him / her in the last 12 months? ☐No ☐Yes
5. Your height: _____ feet _____inches
6. Your weight: _____ lbs.
7. Are you on any medications? ☐No ☐Yes

   If yes, what type & amount of medication? _____

   _____
8. If there is anything else we should know about your health, please tell us below:

   _____

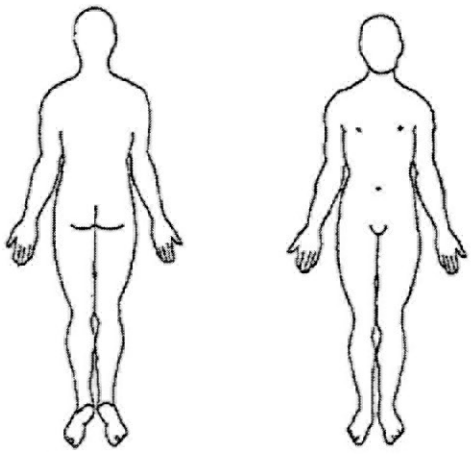
   _____

Please Mark One Box For Each Item	No	Yes (for less than 12 mos)	Yes (for more than 12 mos)	Please Mark One Box For Each Item	No	Yes (for less than 12 mos)	Yes (for more than 12 mos)
Smoking	☐	☐	☐	Are you pregnant?	☐	☐	
Diabetes	☐	☐	☐	Sexual dysfunction	☐	☐	☐
Heart condition	☐	☐	☐	Bladder / bowel problems	☐	☐	☐
High blood pressure	☐	☐	☐	Groin numbness	☐	☐	☐
Chest pain	☐	☐	☐	Arthritis	☐	☐	☐
Stroke	☐	☐	☐	Osteoporosis	☐	☐	☐
Kidney condition	☐	☐	☐	Psychological condition	☐	☐	☐
Blood clot / DVT	☐	☐	☐	Seizures	☐	☐	☐
Metal implants / pacemaker	☐	☐	☐	Dizziness / faintness	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	Ringing in ears	☐	☐	☐
Cancer	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐
Difficulty swallowing	☐	☐	☐	Other allergy	☐	☐	☐
Unexplained weight loss	☐	☐	☐	Fractures	☐	☐	
Double vision	☐	☐	☐	Infection	☐	☐	
Night sweats / night pain	☐	☐	☐	Fever / nausea	☐	☐	

CURRENT EPISODE REPORT

CORE|PT

1. What is your main goal for physical or occupational therapy? _____
2. Have you had these symptoms previously? ☐Yes ☐No
3. Date of injury / symptom onset: _____/_____/20_____ ; _____
4. Have you received physical or occupational therapy previously for this same condition? ☐No ☐Yes
   If yes, when and where? _____
5. Please mark the areas where you feel symptoms on the body diagram below:



6. Please check the boxes that best describe what you are feeling: (Check all that apply)
   ☐ Sharp pain ☐ Dull/aching pain ☐ Numbness ☐ Tingling
7. Do your symptoms:
   ☐ Come and Go ☐ Constantly bother you
8. When do you feel **best** (have the least symptoms)?
   ☐ Morning ☐ Afternoon ☐ Evening/Night ☐ After exercise
9. When do you feel **worst** (have the most symptoms)?
   ☐ Morning ☐ Afternoon ☐ Evening/Night ☐ After exercise
10. How are you currently able to sleep due to your symptoms? (Check all that apply)
    ☐ No problem sleeping ☐ Difficulty falling asleep
    ☐ Awakened by pain ☐ Can only sleep with medication
11. What position or activities make your symptoms **better**? _____
12. What position or activities make your symptoms **worse**? _____
13. Does coughing, sneezing, or taking a deep breath make your pain worse? ☐Yes ☐No
14. Do activities like bending, sitting, lifting, twisting, and/or turning in bed make your pain worse? ☐Yes ☐No
15. Do you have pain with bowel, bladder, or sexually related activities/functions? ☐Yes ☐No
16. On a scale from 0 to 10, with 0 being "no pain" and 10 being "worst pain imaginable", please rate:

Pain Rating	No Pain 0	1	2	3	4	5	6	7	8	9	Worst Pain Imaginable 10
Currently while completing this survey:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Best your pain has been during the past 24 hrs:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst your pain has been during the past 24 hrs:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date:

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection

		❑ Other:	❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____