New Patient Intake Package

- Welcome Letter
- Consent Form
- Medical History
- Medication List

Welcome to CORE Physical Therapy

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

Insurance

Prior to your evaluation your primary and secondary insurance will have been verified and if necessary, authorization obtained. 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.

Co-pay/deductible payments

Payments are due at the time of service.

Scheduling

Any questions regarding scheduling should be directed to the front desk at Core Physical Therapy. It is our desire to provide the upmost consistent care. Please make sure to schedule your appointments three to four weeks in advance.

Appointment Time

We try to keep on schedule as much as possible. Please contact us if you are delayed. If you are still in the waiting room 10 minutes after your regularly scheduled appointment, please come to the front desk.

When you arrive for the evaluation please come to the reception desk and have with you:

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

What happens next?

After the evaluation has been completed, the therapist will discuss with you a treatment program. We will tailor your program to your needs.

If you have any questions or we can be of any assistance to you please call us at (302) 734-0100.

We look forward to seeing you.

Sincerely, The Staff of CORE Physical Therapy

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, drug, alcohol, and/or a psychiatric diagnosis.

PRIVACY PRACTICES: I acknowledge and agree to CORE Physical Therapy Notice of Privacy Practice. If you would like a copy for review, it will be provided at your request or can be found on our website.

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 $25 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 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 _____

Printed Name: _____

Name_____

Medical History

General Information

1) If applicable, what is the date of the next visit with your referring clinician? ____/____/____

2) Have you had surgery related to this injury/symptom onset? Yes___ No___

3) Are you presently working? Yes____ No____

4) Do you have a Primary Care Physician/ Family Doctor? Yes___ No___

5) Your height: _____feet _____ inches. Your weight: _____ lbs.

6) Age: _____

7) Is there anything else we should know about your health?

_____

Please Mark One Box for Each Item	No	Yes, less than 12 months	Yes, more than 12 months	Please Mark One Box for Each Item	No	Yes, less than 12 months	Yes, more than 12 months
Smoking				Are you pregnant?			N/A
Diabetes				Sexual Dysfunction			
Heart Condition				Bladder/Bowel Problems			
High Blood Pressure				Groin Numbness			
Chest Pain				Arthritis			
Stroke				Osteoporosis			
Kidney Condition				Psychological Condition			
Blood Clot				Seizures			
Metal Implants				Dizziness/Faintness			
Breathing Difficulty/ Asthma				Ringing in Ears			
Pacemaker				Sensitive to Latex			
Difficulty Swallowing				Other Allergy			
Unexplained Weight Loss				Fractures			
Double Vision				Infection			
Night sweats/pain				Fever			
Cancer				Nausea			

Name_____

1) What is your main goal for physical therapy?

_____

2) Have you had these symptoms previously?

_____

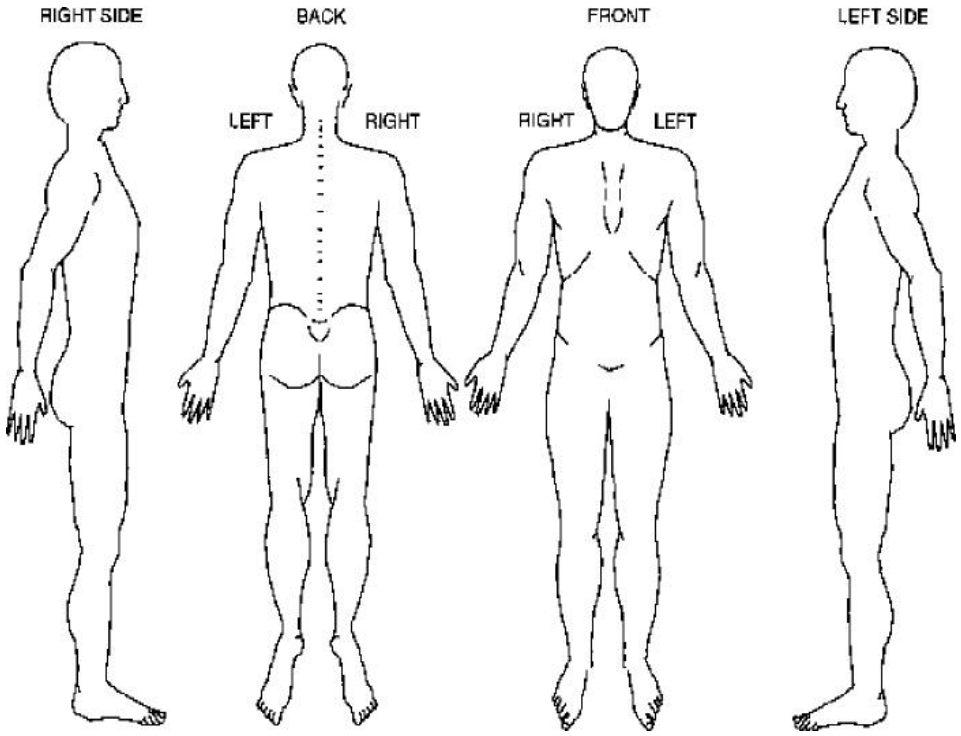
3) Date of injury or onset of symptoms? ____/____/____

4) Have you received physical therapy previously for the same condition? No___ Yes___

5) Please mark any area (s) of your body in which you are having ongoing symptoms.

Use the symbols listed below to describe the location and the type of pain or unusual feelings you are having by drawing them on the pictures.

OOOO	**Pins and Needles**
XXXX	**Numbness**
//////////	**Pain**
= = = =	**Other**



Name_____

Using the number rating system below:

Pain level **now:** _____ (0-10)

Pain level at **best:** _____ (0-10)

Pain level at **worst:** _____ (0-10)

None	Mild	Moderate	Severe

6) Do your symptoms:

Come and go____ Constantly bother you____

7) When do you feel best?

Morning ____ Afternoon _____ Evening ____ After exercise____

8) When do you feel worst?

Morning ____ Afternoon _____ Evening ____ After exercise _____

9) How are you currently able to sleep?

No problem sleeping ____ Awakened by pain _____

Difficulty falling asleep ____ Can only sleep with medication _____

10) What position or activity makes your symptoms better?

_____

11) What position or activity makes your symptoms worse?

_____

12) Does coughing, sneezing, or taking a deep breath make your symptoms worse?

No ____ Yes____

13) Do you have pain with bowel, bladder, or sexually related activities? No____ Yes ____

Name______________________________

Medication List

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:

Name______________________________

		☐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:
		☐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: ____