For Office Use Only:

Name: _____

DOB: _____

Date: _____

Intake Form

Patient Name (Last, First, MI): _____ MALE FEMALE

Date of Birth: _____ /_____ /_____ SSN: _____

Address: _____ City/State/Zip: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Email: _____

Would you like to receive appointment reminders by (check one): **Text _____ Email _____**

Do you give us permission to leave a message on your answering machine if we are unable to reach you? (check one):

Yes _____ No _____

Referring Provider: _____

Person responsible for Physical Therapy expenses (if patient is under 18)

Name: _____ Relationship: _____ DOB: _____ / _____ / _____

Address: _____ City/State/Zip: _____

Phone Number: ( ) _____ - _____

Insurance Policy Holder (if other than yourself)

Name (Last, First): _____ DOB: _____ / _____ / _____ Relationship: _____

****EMERGENCY CONTACT****

Name: _____ Relationship: _____ Phone#: ( ) _____ - _____

Address: _____ City/State/Zip: _____

I do not wish to name a contact at this time _____

Name: _____

DOB: _____

Date: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby give my consent for **ACHIEVE THERAPY** to furnish medical care and treatment that is considered necessary and proper in diagnosing her/his physical condition.

Patient Name: _____ **Date:** _____

Patient/Guardian Signature: _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all physical therapy benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to **ACHIEVE THERAPY**. A photocopy of this assignment is to be considered as valid as the original. I authorize Achieve Therapy to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian Signature: _____ **Date:** _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as courtesy to you. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services bill by us, you recognize an obligation to promptly remit same to **ACHIEVE THERAPY**.

The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of chargers for services rendered to you.

When you pay by check you expressly authorize **ACHIEVE THERAPY** to electronically debit your account for the amount of the check. If your check is dishonored for any reason you will be charged the amount of the check plus a processing fee up to the state maximum legal limit. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however mean that **ACHIEVE THERAPY** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fess and attorney fees.

I have read the above information and agree to pay Achieve Therapy for any and all balances not covered by insurance.

Patient/Guardian/Responsible Party Signature: _____

Clinic Representative/Witness Signature: _____

Name: _____

DOB: _____

Date: _____

ACHIEVE THERAPY RESPONSIBILITES

We are required by law to maintain the privacy of your Protected Health Information, to comply with the privacy policies outlined in this notice, and to provide you this notice of privacy practices. Achieve Therapy is permitted by law to reserve the right to amend or modify our privacy policies, our practices, and this document. You may review or receive copies of your PHI by submitting a written request. Achieve Therapy requires that request to review your PHI, receive copies of your PHI, or request to restrict disclosures of your PHI, be submitting in writing. Forms to request information may be obtained from the Privacy Officer.

COMMENTS OR COMPLAINTS:

You may submit a comment or complaint about our privacy practices by sending a letter describing your concerns to:

Privacy Officer

Achieve Therapy

1425 S Columbia Rd

Grand Forks, ND 58201

Patient Signature: _____ **Email Address:** _____

Date of Birth (mm/dd/yyyy): _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the Achieve Therapy Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Patient/Authorized Agent Signature: _____ **Date:** _____

TO BE COMPLETED BY ACHIEVE THERAPY IF ACKNOWLEDGEMENT IS NOT OBTAINED:

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

____ Patient (or authorized agent) refused to sign after being requested to do so

____ Minor presented without parent or authorized agent. NPP, acknowledgment form, and self-addressed envelope sent home with the patient

____ Other (please describe):_____

Signature of Achieve Therapy Associate: _____ **Date:** _____

Name: _____

DOB: _____

Date: _____

Medical History

Allergies	Y	N	Dizzy Spells	Y	N	Muscular Disease	Y	N
Anemia	Y	N	Emphysema/Bronchitis	Y	N	Osteoporosis	Y	N
Anxiety	Y	N	Fibromyalgia	Y	N	Parkinson's	Y	N
Arthritis	Y	N	Headaches	Y	N	Rheumatoid Arthritis	Y	N
Asthma	Y	N	Hepatitis	Y	N	Seizures	Y	N
Autoimmune Disorder	Y	N	High/Low Blood Pressure	Y	N	Smoking	Y	N
Cancer	Y	N	High Cholesterol	Y	N	Speech Problems	Y	N
Cardiac Conditions	Y	N	HIV/AIDS	Y	N	Strokes	Y	N
Cardiac Pacemaker	Y	N	Incontinence	Y	N	Thyroid Disease	Y	N
Circulation Problems	Y	N	Kidney Problems	Y	N	Tuberculosis	Y	N
Currently Pregnant	Y	N	Metal Implants	Y	N	Vision Problems	Y	N
Depression	Y	N	MRSA	Y	N			
Diabetes	Y	N	Multiple Sclerosis	Y	N			

Describe any other medical conditions

Fall History:

Injury as a result of a fall in the past year? YES NO

Two or more falls in the past year? YES NO

Surgical History: (*please list below)*

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Current Medications: (*please list below)*

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Currently not taking any medications ◯ Medications scanned on a separate list ◯