LONGEVITY
PHYSICAL THERAPY & WELLNESS

PATIENT INTAKE

Appt. Date/Time: ___/___/___ @ ___

Patient Name (as it appears on ins. card): _____ DOB: ___/___/___

Patient Address: _____

Email Address: _____ Phone Number: _____

Referring MD: _____ Patient Diagnosis: _____

Auto Related? **Y** or **N** Is Patient currently in Home Health? **Y** or **N**

Has Patient had PT this year: **Y** or **N** Approximate # of visits: _____

Primary Insurance: _____ Plan Name: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: ___/___/___

Relationship (circle one) : Self Spouse Child Other: _____

Claims Address: _____

Insurance Phone #: _____

Secondary Insurance: _____ Plan Name: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: ___/___/___

Relationship (circle one) : Self Spouse Child Other: _____

Claims Address: _____

Insurance Phone #: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

I, the undersigned, do hereby agree and give my consent for Longevity PT & Wellness to furnish medical care and treatment to the patient named above considered necessary and proper in diagnosing or treating his/her physical condition.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I do hereby give my permission to LONGEVITY PT & WELLNESS to furnish my insurance carrier(s) any and all information pertaining to my medical records. (You have the right to refuse to sign this acknowledgement if you so choose).

Patient/Guardian Signature: _____ Date: _____

(Staff Only) Intake completed by: _____ Date: _____

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PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Surgery or injury: _____

Referring Physician: _____ Family Physician: _____

Height: ___ ft ___ in Weight: _____ lbs (This information is required for insurance purposes)

Current Medication(s): _____

Current Pain Level (circle): **1 2 3 4 5 6 7 8 9 10** Have you had PT before? **Y** or **N**

Have you had any of the following medical or rehabilitative services for THIS INJURY/EPISODE?

YES	NO		YES	NO	
___	___	Chiropractor	___	___	General Practitioner
___	___	EMG/NCV	___	___	MRI
___	___	Massage Therapy	___	___	Neurologist
___	___	Myelogram	___	___	Orthopedist
___	___	Occupational	___	___	Podiatrist
___	___	Therapy Physical Therapy	___	___	X-Ray
___	___	Emergency Room Care	___	___	CT Scan

Other: _____

Do you have or have you ever had any of the following? (Mark a check on either the yes or no column)

YES	NO		YES	NO	
___	___	Asthma/Bronchitis Angina	___	___	Emphysema
___	___	Shortness of breath/chest pain	___	___	Vision/Hearing Difficulties
___	___	Coronary Heart Disease	___	___	Numbness/Tingling
___	___	Do you have a Pacemaker?	___	___	Dizziness/Fainting
___	___	High Blood Pressure Heart	___	___	Bowel/Bladder Problems
___	___	Attack/Surgery Stroke/TIA	___	___	Weakness
___	___	Congestive Heart Disease	___	___	Weight Loss/Energy Loss
___	___	Blood clot/Emboli	___	___	Hernia
___	___	Epilepsy/Seizures	___	___	Varicose Veins
___	___	Thyroid Disease/Goiter	___	___	Allergies Any
___	___	Anemia	___	___	Pins/Metal Implants
___	___	Infectious Diseases	___	___	Joint Replacement Surgery
___	___	Diabetes	___	___	Neck Injury/Surgery
___	___	Cancer or Chemo/Radiation Arthritis	___	___	Shoulder Injury/Surgery
___	___	Osteoporosis	___	___	Elbow Injury/Surgery
___	___	Gout	___	___	Back Injury/Surgery
___	___	Sleeping Problems/Difficulties	___	___	Knee Injury/Surgery
___	___	Emotional/Psychological Diagnosis	___	___	Leg/Ankle/Foot Injury/Surgery
___	___	Severe/Frequent Headaches	___	___	Are you pregnant?
			___	___	Do you use tobacco?

Patient/Guardian Signature: _____ Date: _____

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COMMUNICATION CONSENT

By signing below, I consent to the following methods of communication from LONGEVITY PT & WELLNESS and their staff regarding my medical care and appointments:

Please check which contact methods you consent to:

☐ Phone

☐ Email

Patient/Guardian Signature: _____ Date: _____

Insurance Assignment and Medical Records Release:

I, the undersigned, do hereby give my permission to LONGEVITY PT & WELLNESS to furnish my insurance carrier(s) any and all information pertaining to my medical records. I also authorize release of my personal HealthCare information to the following individuals:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Patient/Guardian Signature: _____ Date: _____

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CANCELLATION POLICY

We reserve the right to charge $50.00 for a missed appointment without a 24 hour advanced notice or for failing to arrive for an appointment without notice. It is important to note that we pride ourselves in helping people get better. It is impossible to do so if you do not keep your appointments. Help us and you succeed by keeping your appointments.

Patient/Guardian Signature: _____ Date: _____

HIPPA PRIVACY NOTICE & PATIENT RIGHTS ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I also acknowledge that I have been given the opportunity to review my patient rights which includes treatment without discrimination or exclusion based on race, color, national origin, age, disability, sex, religion or any other protected status. I also understand that I have the right to be provided interpretation services, both verbal and in writing during my treatment.

I understand that I have the right to file a grievance with Longevity PT & Wellness Compliance Officer or with the U.S. Department of Health and Human Services, or Office of Civil Rights if I believe that Longevity PT & Wellness has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Patient's Name Printed: _____

Patient's or Responsible Parties Signature: _____ Date: _____

Responsible Parties Relationship to Patient: _____