Patient Intake Form

Hernandez - THERAPY CLINIC -

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)		Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Primary Care Provider (where you go for your routine medical care)		☐ None ☐ Doctors Care is my primary care provider			
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Preferred Pharmacy Are you interested in using the Doctors Care In-Center Pharmacy? ☐ Yes ☐ No

Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on the back of the insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on the back of the insurance card)		Phone

New Patient Information and Consent

Where did the injury occur? (example: park)

Accident/Injury Information

Not Applicable ☐

Were you struck by an object? Yes ☐ No ☐ If yes, what type of object? _____

Where did you fall? (example: kitchen, bathroom, garage) Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail? ☐ Yes ☐ No

Who may receive information on your behalf regarding testing or referrals? Name: _____

CONSENT FOR CARE AND TREATMENT:

I, _____ hereby agree and give my consent for Hernandez Physical Therapy Clinic to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. ___(initial)

FOR MINORS ONLY: CONSENT FOR CARE: As a parent and/or legal guardian, I authorize Hernandez Physical Therapy Clinic to treat the minor patient named in the attached forms while I am not present. _____(parent/guardian initial)

By signing below, I agree that all the above information is correct and that I authorize Hernandez Physical Therapy Clinic to provide me with therapy services and to furnish my physician, insurance company, or attorney information concerning my injury and treatment.

Patient Signature (Parent/Guardian if necessary):_____ Date: _____

Commitment to Physical Therapy

Late, No-Show, Cancellation and Re-scheduling Policies

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we feel we must do everything within our power to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

Commitment to your appointments

- Except for serious emergencies, your recovery depends upon attending all your appointments.
- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the canceled or rescheduled visit as possible.
- Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. We will inform your physician of the fact that your service has been discontinued due to noncompliance with the prescribed rehabilitation order.

Late Policy

- If you are less than 15 minutes late and have contacted Hernandez Physical Therapy Clinic to warn us that you'll be late, you may complete the remaining time scheduled for your session, **knowing that you will not receive a full session**.
- If you are more than 15 minutes late and have not contacted Hernandez Physical Therapy Clinic, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a $65 fee.

No-Show Policy

- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you a $65 no-show fee.
- Reminder Calls: While we offer automated reminder calls as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS. If reminder calls do not go out, and you do not show up for your appointment, you will still be charged the $65 no-show fee.

Cancellation Policy

- If you need to reschedule a session, you are more than welcome to do so, if you provide more than 24 hours' notice before your scheduled appointment.
- Late Cancel: If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $65 cancellation fee.

Re-Schedule Policy

- If you need to cancel a session, you are more than welcome to do so if you provide more than 24 hours' notice before your scheduled appointment.
- Late Reschedule: If you try to reschedule an appointment within 24 hours of your appointment this is considered a Late Reschedule and we reserve the right to charge you a $65 cancellation fee unless:
    - You reschedule your appointment to later the same day (if there is time available). OR
    - We are able to fill your vacated slot with another client.

Paying, Cancellation, and No-Show Fees

- Cancellation and No-Show fees are not billable to any form of insurance.
- To resume treatment following a late cancel, late reschedule, or no-show, the $65 fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to turn your care back to your referring physician.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance with their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

_____ _____

Patient or Guardian Signature Date

Payment and Insurance Policy

FINANCIAL POLICY:
It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, co-insurance, and deductibles at the time of each visit. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month.

PATIENT'S RESPONSIBILITY:
It is the patient's responsibility to pay for any balances due promptly for services rendered, regardless of insurance claims status.
_____(Initial)

It is the patient's responsibility to:

- Understand their insurance policy and ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurance, and/or deductibles at the time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescriptions for physical therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days before their 1st visit.

INSURANCE PATIENTS
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Hernandez Physical Therapy Clinic to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Sports & Performance Physical Therapy. _
_____(Initial)

MEDICARE PATIENTS – (*please provide card)*
Have you had any PT this year provided in your home or another outpatient clinic? ☐ Yes, ☐ No _____# of visits
Do you currently have Medicare home services? ☐ Yes ☐ No
Medicare ID:_____

SELF PAY PATIENTS:
For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service.
_____(Initial)

VOLUNTARY TERMINATION OF TREATMENT:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. _____(Initial)

I have read the above information and **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT**.

_____ _____
Patient or Guardian Signature Date