Dadez Physical Therapy
471 S Arch Ave
New Richmond, WI 54017

Name:_____

DOB :_____

EMAIL: _____

☐ Check here to receive emailed statements.

Patient Health History and Intake

Today's Date _____ Age _____ Height _____Weight _____ Occupation _____

Emergency Contact_____Relationship: _____Phone:_____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about Dadez Physical Therapy? _____

For what problem(s) or areas of your body are you being seen for in Physical Therapy?

_____

When or how did this injury occur? Please be specific. If the condition is long standing or on-going, please provide an approximate date/year/age of onset. Please provide date of most recent flare up or worsening of condition.

_____

What activities does this condition limit you from doing? What activities are you still able to do but cause pain?

_____

Please list any other treatments that you have received for this condition (ie. chiropractor, therapy)

_____

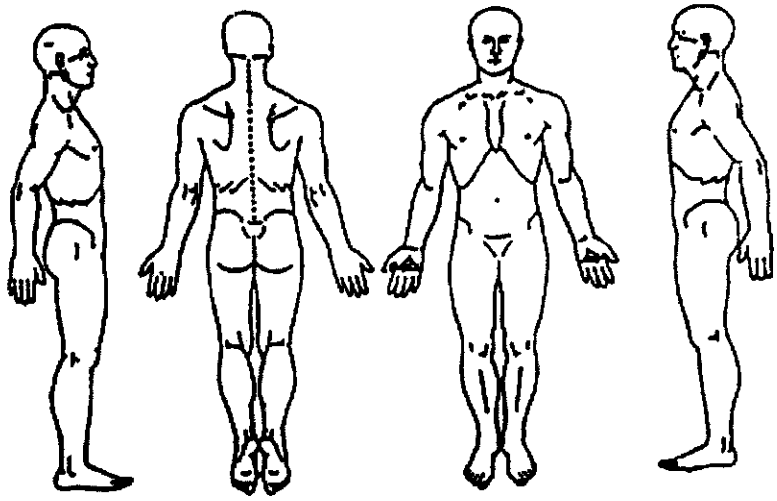
Any previous surgery (all not just related to today's visit)? YES NO If **YES** please list date and type

_____

Have you had or currently have any of the following conditions/problems, please circle all that apply.

Heart Disease	High Blood Pressure	Cancer	Arthritis	Lymes Disease
Allergies	Diabetes	Metal Implants	Loose Joints	Pregnancy
Pacemaker	HIV/AIDS	Latex Sensitivity	Tape Allergy	Visual Impairment
Hearing Impairment	Bruise Easily	Fractures	Asthma	Mononucleosis
Present Smoker	Past Smoker	Pneumonia	Sinus Infection	Tailbone Hit
Bowel Issues	Bladder Issues	Other: _____		

Please indicate where you are experiencing your pain on the body diagram.



What is your pain range in the past week? (0 = no pain 1= minimal 10 = severe)

Least _____ Most _____

When is your pain the least? _____

When is your pain the most? _____

Please circle the words or phrases below that best describe your pain:

Constant Occasional Burning Throbbing Aching Tingling Sharp

In one place Pins&Needles Moves around Better w/Activity Worse w/Activity Pain at Rest

Have you fallen more than once within the last year? Or has any fall resulted in injury? YES NO

Is this problem work related? YES NO

Have you received any of the following for this condition? Please indicate date and location.

X-ray ___/___/___ MRI ___/___/___ CT Scan ___/___/___ Injection Type _____ ___/___/___

_____ _____ _____ _____

Please circle the best way for us to help you learn a home exercise program

Verbal Instruction Written/Illustrated Instruction Demonstration

How much time are you willing to commit to a daily exercise routine to promote healing and wellness?

15 min ____ 30 min ____ 45 min ____ 60 min ____

Patient Signature_____ Date _____

Reviewed by Therapist _____Date _____

MD Follow Up _____ ☐ None Scheduled

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Patient Name:	Date of Birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications.
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of prescription medication (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc..)

Over the Counter medication or nutritional supplements	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc..)

Patient Updated:	Date:	Patient Updated:	Date:
Therapist Reviewed:	Date:	Therapist Reviewed:	Date:

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Please review and sign below

Authorization for Treatment: I voluntarily consent to be treated at Dadez Physical Therapy, Inc. consisting of an evaluation and treatment procedures. I understand that there are no guarantees in regards to the results of the evaluation and/or treatment to be provided by the knowledgeable staff at Dadez Physical Therapy, Inc If at any time I am uncomfortable with any technique, procedure or practice, I will notify the treating therapist.. I authorize Dadez Physical Therapy, Inc to provide treatment. If I refuse to sign the consent and still obtain treatment from Dadez Physical Therapy, Inc. consent is implied.

Financial Policy: I request that payment be made to Dadez Physical Therapy, Inc. on my behalf for services rendered to me by Dadez Physical Therapy, Inc. I agree that any balance on my account that is not covered by insurance and any collection fees to collect on delinquent accounts will be my responsibility until my account is paid in full. If my healthcare provider, insurer, or plan requires a physician referral or prior authorization and one is not obtained I may be responsible for partial or full payment for physical therapy services rendered to me.

Cancelation/No Show Policy: A twenty four hour notice is required if you are unable to attend your scheduled appointment. Failure to give notice will result in a $40.00 cancellation or no show fee. Payment of this fee will be paid at the time of your next scheduled appointment. If you have repeated cancellations within twenty four hours of your appointment or no show appointments, you will be scheduled under our "Same Day Appointment" policy. This policy allows you to only schedule same day appointments to ensure that you are able to make it to your scheduled appointment.

Patient Privacy: I have been provided the Health Insurance Portability and Accountability Act (HIPAA) Policy for review and know that if I would like a copy to keep. I can request one.

Release of Information: I consent that Dadez Physical Therapy, Inc. may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies.

Prompt Pay Policy: If you **DO NOT** want your services billed to an insurance company, charges must be **paid in full** at the time of service in order to receive the discount. The prompt pay charges are as follows: Initial Evaluation $160.00 and $35.00 per 15 minutes for additional appointments. If a supply or custom orthotics are issued there will be additional charges. **I DO NOT** want my services billed to an insurance company, and **will NOT** do so myself.

Self Referral: I understand that if I have not been referred by a physician I will be considered a Self-Referral and can be treated for 90 days. After that time if I choose to continue treatment that is being billed to my insurance I will need to obtain an order from a licensed physician.

Medicare Patients Only: Are you currently in or have you in the past 30 days received any type of Home Health Care Services, physical/speech/occupational therapy from a home health care agency, transitional care or nursing home?
___ Yes ___No
If yes, we cannot treat you today unless you have been discharged. Medicare will not pay for your services. It is your responsibility to inform us if you have had any treatment at an outpatient therapy facility within the past 12 months.

As part of working with my insurance carrier, I recognize that Dadez Physical Therapy, Inc. may be provided with information about my insurance coverage. I understand and acknowledge that Dadez Physical Therapy, Inc. is not responsible for the accuracy of any insurance coverage information shared with me and that I am solely responsible for reviewing my insurance plan documents and /or working with my insurance carrier to determine what my outpatient physical therapy benefits are. By signing below, I agree that I am responsible for the bill for any services for myself or for the patient for whom I am signing.

Signature of Patient/Guardian/Guarantor

Date

Dadez Physical Therapy, Inc
471 S. Arch Ave. New Richmond, WI 54017

Privacy Notice

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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Use of Medical Information by Dadez Physical Therapy, Inc.

Dadez Physical Therapy, Inc. (DPT, Inc.) is permitted to use private health information (PHI) about you for the purpose of providing treatment to you, for the purpose of obtaining reimbursement from third parties for the treatment DPT, Inc. provides to you, and to conduct our normal daily business activities. PHI is any information that specifically identifies you. The uses of PHI may include but are not limited to submitting copies of records by DPT, Inc. billing personnel for purposes of submitting bills and claims to insurance companies, health plans, Medicare, Medical Assistance, and other payers, and for the purpose of appealing denials of reimbursement by third parties for the services provided by DPT, Inc. DPT, Inc may disclose your private medical information to business associates who agree to comply with DPT, Inc.'s private health information policies. DPT, Inc. may disclose your private health information to other health care providers in connection with health care treatment they provide to you. DPT, Inc. may submit your private health information to the Medicare or Medical Assistance programs, for the purpose of health oversight activities, audits, investigations, and claims processing. DPT, Inc. personnel may also review your records for the purpose of evaluating the effectiveness of the treatment, conducting outcomes studies, and evaluating the skills of individual therapists.

DPT, Inc. will not disclose medical information about you for purposes not described in paragraph I above without first obtaining your prior written authorization. In the event you sign an authorization for release of your medical information you have the right to revoke the authorization at any time.

Your Rights

You have the right to request that restrictions be placed upon the use of you health care information but DPT, Inc. does not necessarily have to agree to those restrictions. You have the right to receive confidential communications of protected information. If you desire alternative means of communication please inform the therapist and DPT, Inc. will make reasonable attempts to accommodate you.

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You have the right to inspect, copy and amend your protected health care records. You have the right to amend your health records pursuant to 65 C.F.R. 164.526. You have the right to receive an accounting of disclosures of protected health information. If you receive electronic copies of protected health information you have the right to receive paper copies.

DPT, Inc. is required by law to maintain the privacy of your records and to follow its policies regarding maintaining this privacy. You are entitled to notice if DPT, Inc. changes these policies.

You have the right to file a complaint if you believe these privacy policies have been violated. Complaints should be sent to Dadez Physical Therapy, Inc. 471 S. Arch Avenue, Suite 1, New Richmond, WI 54017, or you can call (715) 246-3809