

PT ONBOARDING

Physical Therapy Intake Form Packet

Patient Name *

First Name

Middle Name

Last Name

PREFERRED NAME**DATE OF BIRTH *****SEX ***

MALE

FEMALE

OTHER

Address *

Address

City

State

Zip

Email Address *

@

Cell Phone *

(000) 000-0000

Home Phone

(000) 000-0000

OCCUPATION *

MARITAL STATUS

SINGLE

MARRIED

DIVORCED

WIDOW

How did you hear about us?

ZOCDOC

INSURANCE WEBSITE

GOOGLE SEARCH

GOOGLE MAPS

FRIEND

REFERRING PHYSICIAN NAME

NAME

PHONE NUMBER

EMAIL ADDRESS

IS YOUR INJURY

AUTO ACCIDENT

WORK-RELATED

EMERGENCY CONTACT RELATIONSHIP

EMERGENCY CONTACT PHONE NUMBER

IS THE PATIENT A MINOR? *

Yes

No

Medical History

PLEASE CHECK AND DATE ANY OF THE FOLLOWING MEDICAL SERVICES FOR THIS INJURY / PAIN EPISODE: *

☐ ORTHOPEDIST

☐ PODIATRIST

☐ CT SCAN

☐ MASSAGE THERAPY

☐ NEUROLOGIST

☐ CHIROPRACTOR

☐ EMG / NCV

☐ OTHER PROCEDURE

☐ GENERAL PRACTITIONER

☐ X-RAYS

☐ MYELOGRAM

☐ NONE

☐ PHYSICAL THERAPIST

☐ MRI SCAN

☐ EMERGENCY / URGENT CARE VISIT

HAVE YOU HAD SURGERY FOR YOUR INJURY / PAIN? *

Yes

No

Please indicate if you have had any of the following:

☐ Asthma,
Bronchitis,
Emphysema

☐ Chronic Fatigue

☐ Anemia

☐ Shortness of
Breath

☐ Chest pain /
Angina

☐ Coronary Heart
Disease

☐ Pacemaker

☐ Low Blood
Pressure

☐ High Blood Pressure

☐ Seizure

☐ Heart Attack / MI

☐ Stroke / CVA

☐ Blood Clot /
DVT

☐ Epilepsy

☐ Thyroid
dysfunction

☐ Infectious
Disease

☐ Diabetes

☐ Cancer /
Chemotherapy
/ Radiation

☐ Arthritis /
Swollen Joints

☐ Osteoporosis

☐ Gout

☐ Sleep Disorder / Sleep
Apnea

☐ Varicose Veins

☐ Allergies

☐ Pins / Metal
Implants

☐ Joint
Replacement

☐ Neck Injury

☐ Shoulder Injury

☐ Elbow / Hand
Injury

☐ Back Injury

☐ Knee Injury

☐ Leg / Ankle / Foot Injury

List any medications (prescription or non-prescription), vitamins, or supplements you are currently taking. SIMPLY ANSWER NONE IF YOU ARE NOT TAKING ANY MEDICATIONS, AND NOT TAKING ANY SUPPLEMENTS. *

Do you smoke

Yes No

Are you pregnant?

Yes No

Are you currently in pain? * Yes No

DATE OF ONSET (WHEN YOUR SYMPTOMS BEGAN MOST RECENTLY) *

PLEASE EXPLAIN YOUR SYMPTOMS (REGION / AMOUNT OF PAIN / HOW OFTEN) *

WHERE IS YOUR PAIN L

RATE PAIN (0 = NONE, 1 =

HOW OFTEN? (# DAYS /

DO YOU HAVE NUMBNI

I HAVE ?'S RE: POSTURE

Please provide us with any other information that would assist us in your care *

WHAT ARE YOUR EXPECTATIONS FOR PHYSICAL THERAPY? THIS GUIDES MY PLAN OF CARE FOR YOU, AND IS THEREFORE IMPORTANT. SELECT ANY THAT APPLY (MAY SELECT MORE THAN ONE). *

- REDUCE PAIN
- IMPROVE MOBILITY
- RETURN TO SPORT
- LEARN HOW TO IMPROVE POSTURE
- LEARN PROPER LIFTING MECHANICS
- LEARN GYM CIRCUIT (S) TO IMPROVE STRENGTH

Physical Activity Readiness Questionnaire (PAR-Q)

Regular physical activity is fun and healthy, and increasingly, more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Instructions

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: select YES or NO.

Questions: *

	Yes	NO
1. Has your doctor ever said that you have a heart condition, or high blood pressure?	☐	☐
2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
3. Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? (Answer NO if your dizziness was associated with over-breathing (including during vigorous exercise)).	☐	☐
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	☐	☐
5. Are you currently taking prescribed medications for a chronic medical condition?	☐	☐
6. Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active?	☐	☐
7. Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered YES to one or more questions:

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

Find out which community programs are safe and helpful for you.

If you did NOT answer YES to any questions:

If you did NOT answer YES honestly to all PAR-Q questions, you can be reasonably sure that you can:

Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.

Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

Delay becoming much more active:

If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or

If you are or may be pregnant – talk to your doctor before you start becoming more active.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

Date

Signature *

ClearUndo

HIPAA NOTICE OF PRIVACY PRACTICES &ACKNOWLEDGMENT

BOUT2BEBETTER PHYSICAL THERAPY INC.

HIPAA NOTICE OF PRIVACY PRACTICES & PATIENT ACKNOWLEDGMENT

NOTICE OF PRIVACY PRACTICES

Federal law (HIPAA - Health Insurance Portability and Accountability Act) requires that we protect your personal health information (PHI) and inform you of your rights.

We use your PHI to:

- Provide and coordinate your care
- Bill and collect payment for services
- Operate and improve our services

We may disclose your PHI without additional consent:

- To other healthcare providers involved in your care
- To insurance companies for reimbursement
- When required by law (e.g., public health, subpoenas)

You have the right to:

- Access and request a copy of your medical records
- Request corrections to your records
- Request limits on disclosures
- Receive a list of entities with whom we shared your PHI
- File a complaint if you feel your rights were violated

A full copy of our HIPAA Notice of Privacy Practices is available upon request and posted at our facility. You may also download it from our website.

PATIENT ACKNOWLEDGMENT

I have received and reviewed the Notice of Privacy Practices from BOUT2BEBETTER PHYSICAL THERAPY INC

I understand how my health information may be used and disclosed.

I understand my rights regarding access, disclosure, and privacy

Date

Signature *

ClearUndo

We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances. However, we require patients to cancel or re-schedule appointments within 24 hours of a scheduled visit.

If you are a no show, or fail to reschedule/cancel an appointment without giving the 24 hours notice a **\$120.00 charge** will be applied to the card on file for each missed appointment. **INSURANCE CANNOT BE BILLED FOR A MISSED APPOINTMENT.** If you **reschedule your appointment within the same week, the late cancellation fee will be waived.**

I am sure you are aware that missing an appointment prevents us from giving you the care needed. However, it is also detrimental to you because it prevents us from scheduling another who needs care as well.

Cancellation Policy

Signature *

ClearUndo

Date

Video / Picture Consent & Direct Physical Therapy

Informed Consent and Release: Videos and Pictures

This Informed Consent and Release ("Agreement") is entered on , by Bout2bebetter Physical Therapy Inc. ("Company") and ("Client").

Client hereby authorizes Company, or agents acting on their behalf, to photograph and / or videotape Client in Company's solediscretion. Client irrevocably grants to Company an exclusive, worldwide, royalty-free, transferable, perpetual license to access, display, publish,

reproduce, distribute, and otherwise use and reuse the results and proceeds of Client's involvement hereunder, along with Client's name, image, voice, likeness, photographs, videotaped recordings, audio recordings, biographical information, and any other personal characteristics or lines (collectively, the "Materials") in any media (now or hereafter known), for strict purposes of mentorship in residency / fellowship programs, course, social media promotion, or online presentations. Company shall not use the Materials for marketing purposes unless Client consents to such use (see below).

I consent to the use of Client's name, image, voice, likeness, photographs, videotaped recordings, audio recordings, biographical information, and any other personal characteristics or lines (collectively, the "Materials") for marketing purposes.

This authorization is effective immediately and may be revoked in writing by the undersigned at any time. Written revocation will not affect any action taken in reliance on this authorization before the written revocation is received.

Date

Signature

Clear

Undo

Telehealth visit ONLY

TELEHEALTH VIDEO VISIT CONSENT

Bout2BeBetter Physical Therapy Inc.

Outpatient Physical Therapy Services

1. Purpose of Telehealth

Telehealth physical therapy services involve the use of secure, real-time audio and video technology to deliver physical therapy care remotely. Services may include evaluation, movement assessment, exercise instruction, education, and progression of care. Telehealth is not a replacement for emergency medical care.

2. Nature and Limitations

I understand that telehealth does not permit hands-on examination or manual therapy. Clinical decisions are based on visual observation, patient report, and movement performance. Telehealth may not be appropriate for all conditions, and in-person care may be recommended.

3. Risks

Potential risks include incomplete assessment, technical difficulties, and limitations in diagnosis or treatment accuracy compared to in-person visits.

4. Benefits

exposure risks.

Potential benefits include improved access to care, convenience, continuity of treatment, and reduced travel or

5. Privacy and Confidentiality

Telehealth sessions are conducted using HIPAA-compliant technology. No sessions are recorded without explicit

written consent. Despite safeguards, there is a small risk of privacy breach due to technology failure.

6. Consent to Participate

I understand the information provided above, have had the opportunity to ask questions, and voluntarily consent

to participate in telehealth physical therapy services.

Signature

ClearUndo

Date

Direct Physical Therapy Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to **45 calendar days or 12 visits, whichever occurs first**, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, **a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.**

Date

Signature *

ClearUndo

Credit Card Authorization: Account reconciliation
(Insurance patient) / Ongoing charges (Gym Members,
Sports Performance)

Recurring charge: I authorize Bout2bebetter Physical Therapy Inc. to make regularly scheduled charges to my Credit Card to cover the cost of services as outlined on Bout2bebetter's Menu of Services (i.e.; self-pay client) OR upon insurance eligibility and benefit verification (i.e.; insurance member). Costs may include a co-payment, and / or a co-insurance amount as determined by my insurance carrier. If I have a deductible, and my deductible applies, I agree that I am responsible for a full visit (I.E.; out-of-network without out of network benefits), OR a discounted rate visit (i.e.; in-network with in-network, active insurance coverage) until my deductible is satisfied. I understand that collected payment is based on a VISIT estimate upon insurance eligibility and benefit verification, and my account will continue to be adjusted as claims are processed, as the VISIT ESTIMATE may differ from the processed claim amount as reflected on the insurance Estimate of Benefit (EOB). I understand I will receive a copy of my EOB from my insurance carrier, and it is my responsibility to review the document, and contact my insurance carrier if I believe there is a discrepancy between the VISIT ESTIMATE and the EOB, as the processed claim "my responsibility" amount is the FINAL amount owed. I understand that if I do not make timely insurance premium payments, my insurance coverage may become inactive, and my responsibility for each visit will be 100% from the date of inactive status.

A receipt for each payment will be emailed directly from Stripe, and the charge will appear on my Credit Card statement.

I (person listed below) authorize Bout2bebetter to charge my Credit Card for services rendered.

I (person listed below) authorize Bout2bebetter to charge my card for **a full visit for any visit that is not cancelled or re-scheduled 24 hours prior to my scheduled appointment. I UNDERSTAND MY INSURANCE CANNOT BE BILLED FOR A MISSED APPOINTMENT.**

Ongoing charge: I give Bout2bebetter permission to debit my account for ongoing transactions. Such charges may include Physical Therapy balance upon receipt of Insurance Estimate of Benefit (EOB), AND / OR Monthly Gym Membership fee due on the First of each month **unless a written emailed cancellation request has been issued to Bout2bebetter Physical Therapy 30 days inadvance of requested cancellation date.**

I (person listed below) authorize Bout2bebetter to maintain my Credit Card information on secure merchant / practice management platform: Stripe. I (person listed below) authorize Bout2bebetter to charge my Credit Card on file.

Date

Signature *

Clear

Undo

Card Uploads (do NOT upload your payment card)

Government issued Photo ID Upload *

Front

Back

Insurance Card Upload (primary insurance) INSURANCE PATIENT ONLY

Front

Back

Insurance Card Upload (secondary insurance) ONLY UPLOAD IF YOU HAVE A SECONDARY INSURANCE

Front

Back