

PATIENT INTAKE AND CONSENT FORM

Attachment B1.003A
Attachment M7.005C

Internal Use Only: A/C# Name A/C Type Office#

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex M F Marital Status S M D W

Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Responsible Party _____ Cell Phone _____

Address _____ E-mail _____

City _____ Injury Area _____

Phone Number _____ Accident Related: Yes No

Relationship to Responsible Party _____ If Accident: Auto Work Other

Nature of Accident _____

Employer _____ SS# _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No

(Continued on next page)

PATIENT INTAKE AND CONSENT FORM

Please Initial Each
as Applicable:

Internal Use Only: A/C# Name A/C Type Office#

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Denali Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: I know and agree that Denali Physical Therapy is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit Denali Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of Denali Physical Therapy This form must be completed in its entirety and must be provided to Denali Physical Therapy prior to initiation of therapy services.

DENALI PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
 REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
 PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? YES NO
 CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
 IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____
 AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
 WHAT WAS DONE? / WHAT WERE THE RESULTS?: _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
 WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
 FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Other _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____

Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> BLOOD THINNERS (Anticoagulants) |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus) | |
| <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____

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DISCLOSURE AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

DATE: _____

PATIENT NAME: _____ Pt #: _____

RELEASE INFORMATION TO: **Denali Physical Therapy**
ADDRESS: **751 E. 36th Ave, Suite 100-101**
Anchorage AK 99503
Phone: 907-563-2122 Fax: 907-563-2123

I hereby authorize **DENALI PHYSICAL THERAPY** to release to the above referenced individual(s) or entity(ies), copies of the following medical records, including mental health information and such reports and/or records pertaining to a serious or communicable disease or infection pertaining to myself:

- Evaluation
- Daily Notes
- Discharge Summary
- Testing
- Progress Notes
- All Records
- Other (describe) _____

Dates of Service Requested: _____

- I would like photocopies mailed to me.
- I would like to arrange to pick records up in the clinic

The above identified information is released solely for the following purpose and that purpose only:

**TO GET MEDICAL RECORDS FROM YOUR PHYSICIAN
TO TALK WITH YOUR INSURANCE CARRIER**

Signature of pt or authorized legal representative
(Describe basis of authority)

Date:

Witness Signature

Date:

(NONE)

Printed Witness Name and Relationship to Patient

AUTHORIZATION REVOKED:

Patient Signature

Date:



www.denalipt.com

ANCHORAGE

751 East 36th Ave., Suite 100 - Anchorage, AK 99503
 Phone: 907.563.2122 - Fax: 907.563.2123

ANCHORAGE NORTH

360 Boniface Pkwy, 27A - Anchorage, AK 99514
 Phone: 907.563.2141 - Fax: 907.563.2163



Primary Concern
P1 - Primary
P2 - Secondary

Pain Level Indicator
(Place # beside body area)

Pain Type
~ - Dull Ache
/ - Shooting
x - Burning
• - Pins and Needles
o - Numbness

Mild	1
Discomforting	2
Distressing	3
Horrible	4
Excruciating	5

Patient Name: _____ Patient: DOB: _____



CANCELLATION/NO SHOW FEE POLICY

(For Non-Medicare Patients)

You play an integral role in the success of your treatment. Your therapist will establish an individual treatment plan for you, including recommendations for frequency and number of treatment visits. Your dedication to attending the recommended number of treatments is vital to ensure progress with your therapy program.

We expect you to keep all of your appointments. However, we understand there may be circumstances in which you may need to cancel or reschedule an appointment.

PLEASE PROVIDE AT LEAST 24 HOURS NOTICE FOR CANCELLATIONS OR FOR RESCHEDULING AN APPOINTMENT.

- **APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A CANCELLATION FEE CHARGED TO THE PATIENT. FEE WILL BE \$50.00.**
- **CANCELLATION FEES MUST BE PAID AT THE NEXT SCHEDULED APPOINTMENT BEFORE TREATMENT BY THE THERAPIST.**
- **PATIENTS ARE RESPONSIBLE FOR PAYING CANCELLATION FEES.**

I HAVE READ AND FULLY UNDERSTAND THE "CANCELLATION/NO SHOW FEE POLICY" STATED ABOVE, AND I AGREE TO ADHERE TO SUCH POLICY.

PATIENT SIGNATURE

DATE