Kathleen Berg DPT, MS, OCS, FAFS & *Integrative Providers*
3858 N Garden Center Way, Suite 102 • Boise, Idaho 83703
phone 208.830.1668 *fax* 208.620.3968
email info@vitampt.com • www.vitampt.com

New Patient Contact & Insurance Information (Please Print)

Today's Date: ______________

Personal Information

Last Name: ______________ First Name: ______________ Date of Birth: ______________

Street Address: ______________ City, State, Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

e-mail address: ______________

Occupation: ______________ Employer Name: ______________ Employer Phone: ______________

Emergency Contact: ______________ Relationship: ______________ Emergency Contact Phone: ______________

Insurance Information

Name of Insured: ______________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent/Guardian

Date of Birth of Insured: ______________ Phone # of Insured: ______________ Employer: ______________

Primary Insurance: ______________ ID#: ______________ Group#: ______________

Secondary Insurance: ______________ ID#: ______________ Group#: ______________

Additional Information

Referring Physician: ______________ Date of Follow Up Appointment: ______________

Is this a Motor Vehicle Accident Claim? Y / N | Date: ______________ State: ______________

Is this a Worker Compensation Claim? Y / N | Claim #: ______________ Adjuster Name/Phone: ______________

How did you hear about us? (Please provide a name if a friend or relative referred you) ______________

Additional Information for MINORS

Parent 1 Name: ______________ Social Security Number: ______________ Date of Birth: ______________

Phone: ______________ Work Phone: ______________ Employer: ______________

Parent 2 Name (optional): ______________ Social Security Number: ______________ Date of Birth: ______________

Phone: ______________ Work Phone: ______________ Employer: ______________

VITAM
Empowering and Nurturing Integrative Therapies
PHYSICAL THERAPY

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Health Information

Today's Date: ______________

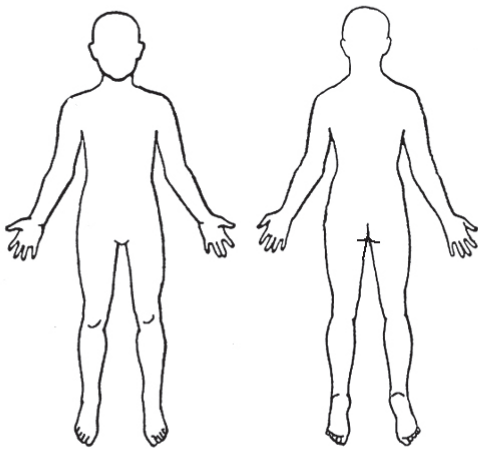
Reason for Attending & Intended Outcome

Name: ______________________ Age: ______

I am attending Vitam because: ______________________

The desired outcome I seek is: ______________________

Current Health Status



Tight: tttt

Numbness/Tingling: 0000

Aching: ####

Burning: BBBB

Sharp/Stabbing: ////

Catching: CCCC

Please rate the intensity of your pain (0=no pain, 10=worst pain/ emergency)

At Best (0-10) ______________

At Worst (0-10) ______________

On Average (0-10) ______________

What movements, positions, and/or time of day INCREASE your pain or symptoms? ______________________

What movements, positions, and/or time of day DECREASE your pain or symptoms? ______________________

How long have you had this issue? ______________________

Have you experienced this issue before? Please describe the onset with date(s) & history of the issue: ______________________

Describe what else you have tried to remedy this issue: ______________________

What activities are you apprehensive with or are no longer able to do that you would like to? ______________________

Please rate the following items on a scale of 0-10 (0=low, 10=high/most):

Inactivity: ____ Stress: ____ Fatigue: ____ Depression: ____ Poor Eating: ____ Smoking: ____ Drinking: ____

Are you currently working? Y / N If yes, full duty, no limitations? Y / N If no, how long away from work? ______

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Health Information (Page 2 of 2)

Current Medications & Reason for Taking

Please list all medications (prescriptions & over-the-counter) and the reason for taking them:

Health Information

	Yes	No	Date		Yes	No	Date
Arthritis				Fracture/Broken Bones			
Asthma				Dizziness/Blackouts			
Cancer				Headache/Migraine			
Diabetes				Blood Clots/Vascular			
Fall(s)				Mental or Emotional			
Heart Problems				Incontinence			
High Blood Pressure				Bowel/Digestive Problems			
HIV or Other Blood Disease				Infection			
Lung/Breathing Problems				Stroke/CVA			
Seizures				Pregnancies	#		

Other:

Family History of Concern:

Previous Surgery & Diagnostics

	Yes	No	Date	Please Describe
X-Ray				
CT Scan				
MRI				
EMG Nerve Studies				
Injections				
Joint Replacement				
Orthopedic Surgery				
Heart Surgery				
Fracture Reductions				
Joint Manipulations				
Spinal Surgery				
Other Surgeries				

What activities would you like to return to after therapy?

❑ Walk/Hike ❑ Cycling ❑ Run ❑ Weights ❑ Skiing ❑ Dancing ❑ Gardening ❑ Golf ❑ Swimming ❑ Gym ❑ Yoga
Other:

Patient Signature: Date:

Legal Guardian Signature: Date:

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Physical Therapy Policies & Consent

Informed Consent for Treatment

I understand there are inherent risks with Physical Therapy treatment because I will be asked to exert effort and perform activities with increasing levels of difficulty, which may increase my current level of discomfort. I am advised that I have the right to an explanation of treatments or procedures utilized including their benefits and risks as well as reasonable alternatives to the proposed therapy. I authorize the staff at Vitam to perform and advise such treatment and procedures as deemed appropriate to improve my condition. I understand that the practice of medicine is not an exact science & as such no guarantees can be made as to the result of Physical Therapy.

Initial _______

Medical Assignment of Benefits

I understand that it is my responsibility to know the status, benefits & policy requirements of my individual insurance coverage and that the insurance contract is between the insurance company and myself. I understand that Vitam will gladly call my insurance company to inquire about current benefit coverage but that insurance companies will not guarantee benefits over the phone and as such this information will only be used as a guideline. I hereby authorize payment of medical benefits directly to Vitam for all services rendered.

Initial _______

Financial Consent

I understand and am in agreement with the following financial policy:

- Vitam is committed to providing quality physical therapy at an accessible & reasonable cost.
- If I do not have insurance, physical therapy benefits included in my insurance, or my benefits run out I may continue receiving services on a "cash pay" basis.
- It is my responsibility & I agree to pay all copays, co-insurance, or "cash pay" estimated amounts at the time of service.
- If at any point my insurance coverage changes, I am to notify Vitam staff prior to my next visit. Failure to do so will result in me being responsible for the full amount of services.
- The process of collecting & receiving insurance payments may take 2-8 weeks. If for any reason my insurance does not pay for the services within 90-days of the services provided, I shall assume responsibility for the total amount owed.
- It is my responsibility to pay for all uncovered services within 30-days after my insurance has paid their portion.
- Insurance coverage for physical therapy is exclusive and does not include coverage for other therapies offered at Vitam including but not limited to personal training, wellness consultations, yoga, acupuncture, massage, other providers or educational services.
- If I neglect to pay my balance within 30-days from the date of my final statement, a $50 collection fee will be added to my account which may be referred to a collection agency.

Initial _______

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Physical Therapy Policies & Consent

Release of Information

I authorize Vitam to release to insurance carriers, government agencies, and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment.

Initial _______

Cancellation & No-Show Policy

A scheduled appointment must be cancelled at least 12 hours in advance or a $40.00 Late Cancel/No Show Fee will be assessed. This fee is not billable to any insurance carrier. I agree to pay the fee in full at my next visit or have my credit card on file charged. I understand that at least a 24-hour cancellation notice is requested to allow another person in need the opportunity to take my reserved appointment. I understand that multiple cancellations or no-shows will result in my dismissal from care and that a note may be sent to my referring provider of such.

Initial _______

Your Information & Rights to Privacy

Vitam adheres to the guidelines outlined by the Health Insurance Portability and Accountability Act (HIPAA) to protect the information stored about my care (past, current, and future plans). I understand that my information is used for the following reasons:

- To conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- To obtain payment from third party payers
- To conduct normal healthcare operations such as quality assessments and certification

I understand that I have received access to, have reviewed the Notice of Privacy Practices and agree to the liability limitations explained therein. I understand that I have the right to request restrictions as to how my information may be disclosed but that Vitam is not required to agree to the restrictions requested.

Initial _______

____ ____________________

Signature of Patient or Legal Representative Date Relationship to Patient

____

Printed Name of Patient