Jaworski Physical Therapy, Inc.
Patient Intake Form

Last Name:	First Name:	Middle Initial:	SSN:

Address:	City:	State:	Zip Code

Home Phone:	Cell Phone:	E-Mail Address:

Height:	Weight:	Sex ☐ M ☐ F	Date of Birth:

Employer:	Work Phone Number:	Occupation:

Emergency Contact	Phone Number	Relationship to Patient:

Physician Information:

Referring Physician:	Phone Number:

Family Physician:	Phone Number:

P**ast History: Please check if you have or ever had one of these conditions or problems.**

☐ Allergies	☐ Circulation problems	☐ Hepatitis	☐ Neck/arm pain
☐ Aneurysm	☐ Currently pregnant	☐ High Cholesterol	☐ Open Wound (current)
☐ Anxiety	☐ Depression	☐ High Blood Pressure	☐ Osteoporosis
☐ Arthritis	☐ Diabetes	☐ HIV/AIDS	☐ Parkinson's disease
☐ Asthma	☐ Dizzy Spells	☐ Incontinence	☐ Rash (current)
☐ Autoimmune disorder	☐ Emphysema/Bronchitis	☐ Kidney Problems	☐ Rheumatoid arthritis
☐ Back Pain/leg pain	☐ Falls	☐ Joint Replacement	☐ Seizure/epilepsy
☐ Balance problems	☐ Fibromyalgia	☐ Incontinence	☐ Smoking
☐ Blood Clots	☐ Fractures	☐ Low blood pressure	☐ Speech problems
☐ Cancer	☐ Gallbladder Problems	☐ Lupus	☐ Strokes
☐ Cardiac conditions	☐ Headaches	☐ Metal implants	☐ Thyroid Disease
☐ Cardiac pacemaker	☐ Head Injury	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Chemical Dependency	☐ Hearing impairment	☐ MRSA	☐ Vision problems

Please list any relevant surgeries including date: _____

_____

Please briefly describe the problem for which you are seeking treatment _____

_____

Problem is due to: □ Acute Trauma □ Repetitive Motion □ Chronic □Worsening of prior injury □ Gradual onset

□ Other: _____

When did the problem start and/or what was the date of surgery: _____

How did you find us? □ Physician referral □ Returning patient □ Friend/Relative □ Advertisement □ Social media

□ Other :_____

Medicare Only- Additional Questions

Are you currently receiving Home Health Services? □ Yes □ No If yes, name of Agency:
Do you have anyone coming into your home to assist with your care? □ Yes □ No
Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center? □ Yes □ No
Have you received physical therapy or occupational therapy since the first of the year? □ Yes □ No

Consent to Release

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Jaworski Physical Therapy, Inc. ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. I understand that I may request a copy of the Notice of Privacy Practices at any time for my personal use. *By signing this consent, I understand and acknowledge that I have reviewed the "Privacy Notice" before signing this consent. I authorize employees of Jaworski Physical Therapy, Inc. to discuss my health information with the following persons: (Please list)*

_____ _____ _____

Phone Messages: I give permission to leave a message (verbal or text) on my home/cell telephone: ____Yes ____No

General: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

Authorization for Treatment: I know that I am suffering from a condition(s) requiring physical/occupational/speech therapy/ massage therapy and/or athletic training. I hereby voluntarily consent to such treatment and procedures to be performed by employees of Jaworski Physical Therapy, Inc.

Permission to take Photograph: I hereby consent for Jaworski Physical Therapy, Inc. to take a photograph of me only for the purpose to use in my medical chart and will not be disclosed for any other reason without additional permission from me. __Yes ___No

Self Referral: If you have not been referred for therapy by your physician and you would like to have him/her receive a copy of your evaluation, progress and discharge reports, please provide the following information:

Name:_____ Address: _____ City:_____ State: _____ Zip Code: _____

_____ _____
Patient's signature Signature other than patient (if patient is a minor)

_____ _____
Date Relationship

_____ _____
Date Witness (rev 4-22-2015)

Jaworski Physical Therapy, Inc.

Patient Name:_____Date:_____

Private Health Insurance

Name of Private Health Insurance:_____

Address:_____City:_____State:_____Zip:_____

ID#:_____Group#:_____

Cardholder Name:_____ Cardholder Date of Birth:_____

Relationship to Patient: _____ Phone: _____

Address (if different): _____

Worker's Compensation (complete the following)

Place of Employment at Time of Injury:_____

Address:_____City:_____State:_____Zip:_____

Date of Injury:_____ Claim Number: _____

If you have an attorney, please complete the following:

Attorney Name:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Liability/Motor Vehicle Accident (complete the following)

Responsible Auto Insurance Name:_____

Date of Accident:_____Claim#:_____

Address:_____City:_____State:_____Zip:_____

Adjuster Name:_____Adjuster Phone:_____

If you have an attorney, please complete the following:

Attorney Name:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Jaworski Physical Therapy Inc.
MEDICARE SECONDARY PAYER QUESTIONNAIRE
Completed by all Patients Covered Under Medicare

	YES	NO
1. Should this illness or injury be covered by a past Workers Compensation Claim or will you be filing a new claim with the Bureau of Workers Compensation		
2. Are you covered under the Federal Black Lung Program		
3. Are you entitled to benefits through the Veteran's Administration? Do you want us to contact the VA for authorization of these services?		
4. Are these services a result of an accident?		
5. Do you feel someone else is responsible for this illness or injury?		
6. Are these services covered by a Public Health Service (other than Medicare or Medicaid)		
7. Are you entitled to Medicare due to End Stage Renal Failure- If yes please answer the following a. Are you covered by an Employee Sponsored Group Health Plan? b. Are you within the 18 month Coordination of Benefits period?		
8. If you or your spouse are actively employed, are you covered by that Employee Group Health Plan		
9. Are you entitled to Medicare solely due to a disability other than End Stage Renal Failure?		
10. If you answered yes to question number 9, are you are your family member actively employed and covered by that Large Group Health Plan?		
11. Are you currently receiving Home Health Services (for example, nurse, aide, therapist)		

Please Explain any Yes answers:

_____

_____

_____

_____

Signature: _____ Print Name: _____ Date: _____

Name of person who supplied information if different then the patient: _____ (print name)

Relationship to patient: _____ Signature: _____ Date: _____

JAWORSKI PHYSICAL THERAPY, INC.

IMPORTANT SCHEDULING AND FINANCIAL POLICIES

At Jaworski Physical Therapy, we strive to provide excellent care with treatment provided on a one-on-one basis by your therapist. ***The appointments that you make will be reserved specifically for you.*** To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time for your appointments.

We welcome you as a new patient of Jaworski Physical Therapy, Inc. To avoid any misunderstanding we would like to keep you informed of our current financial policies regarding payment for the services we will provide to you.

- As a courtesy , we will try to verify your benefits prior to your first visit. Please note that when we verify benefits, we are simply relaying information provided to us from your insurance company. Jaworski Physical Therapy, Inc. is NOT responsible for any incorrect information that may be provided to us. We strongly suggest that you personally contact your insurance company for verification of your benefits. We have created a questionnaire which you may use to assist you with this process. (Patient Insurance Verification Questionnaire)
- Co-pays, co-insurance and deductibles are dictated by your insurance carrier. Our contract with the insurance carrier requires that we collect these fees.
- Co-pays are due **prior** to the beginning of each treatment session.
- If you have a plan with a co-insurance, we will **estimate** your expected co-insurance and require that it be paid **prior** to the beginning of a treatment session. If you have a deductible that has not been met prior to treatment, you will be required to make a payment toward the deductible at each visit. You will be responsible for any unpaid balance after insurance payments and adjustments. Alternatively, for your convenience you may pre-authorize a credit card payment for any amount still due for any outstanding balance after insurance billing is completed.
- If you do not have insurance coverage, or have exhausted your therapy benefits, we offer a discount on our fee schedule if paid at the time of service. Cash pay service cannot be billed to your insurance company.
- Payment can be made by credit card, check, or cash. We also accept payment through HSA and FSA plans.
- Payment for outstanding balances is due within 30 days of billing. Interest may be accrued at a rate of 1.5% per month on outstanding balances.
- There is a $40 fee for returned checks.
- There is a 25% fee added to any accounts that are turned over to an outside agency for collections.

NO SHOW/CANCELLATION POLICY

Providing one-on-one care to each patient requires that we do not overbook or double book our appointments. As a result, failure to make an appointment is not only a lost opportunity to help you, it is also lost revenue for the practice. If you do not think that you will be able to make regularly scheduled appointments, please ask about our flexible scheduling program.

Please initial that you have read the following policy:

____ I understand that Jaworski Physical Therapy may charge a $30.00 fee in the event that the patient does not show for an appointment and we are not called prior to the appointment or if you cancel more than (3) appointments with less than 24 hours notice. These charges are not covered by insurance and the patient, parent or guardian will be held responsible for payment.

I have read and understand the above policies

_____ _____

Signature Date

Jaworski Physical Therapy Inc.

Medication List

To meet regulatory requirements and to assist the therapist in the treatment of your condition it is important that we are aware of all the medications that you are currently taken. This includes prescription medications, over the counter medications, vitamins and/or herbs. Please provide us a list of your medications, including the medication, dosage, frequency, route taken and reason for taking the medication. If you already have this information on a printed list, you may bring it to your appointment and we will make a copy for your file. Thank you for your cooperation.

Patient Name: ___________________________ Date:_________________________

Medication	Frequency	Dosage	Route Taken	Reason for taking

Jaworski Physical Therapy, Inc.
137 Winckles Street
Elyria, Ohio 44035

Patient Insurance Verification Form

We always encourage that you check your benefits prior to starting therapy. Asking all of the questions on this form will help ensure that you receive the most accurate information possible. If you have any additional questions, please do not hesitate to ask us.

BEFORE YOU CALL YOUR INSURANCE COMPANY, HAVE READY:

Your name (as on your card) _____ Birth date: _____

Subscriber Name (spouse/parent) _____ Birth date:_____

ID Number _____ Group # _____

WHEN YOU CALL YOU INSURANCE COMPANY SAY:

"I am calling to verify my insurance for physical therapy or occupational therapy in an **OFFICE** setting."

Note the date/time and person you are speaking with: _____

It they ask where you are having your therapy: **Jaworski Physical Therapy, Inc.**

ASK THE REPRESENTATIVE TO TELL YOU:

What is the effective date of the plan: _____ Does it run on calendar, plan or group year _____

What is your current deductible?: _____ How much of your deductible has been met? _____

Do you have a co-pay? _____ How much is the co-pay?_____ Will the co-pay be for every visit? _____

Do you have co-insurance? _____ Does it apply to your therapy treatments? _____

What is the co-pay percentage? _____

Are the number of visits limited? _____ Are these visits combined with any other service _____

How many visits have been used? _____Must they be completed in a specific time period? _____

Is pre-certification or prior authorization for treatment required? No / Yes

Is authorization required at any time? _____

Do I require a referral from a physician? Yes / No

_____ _____
Signature Date

PLEASE BRING THIS FORM WITH YOU TO YOUR THERAPY APPOINTMENT