

Appt. Date/Time: ____ / ____ / ____ @ ____

Patient Name (as it appears on ins. card): _____ DOB: ____ / ____ / ____

Patient Address: _____

Email Address: _____ Phone Number: _____

Referring MD: _____ Patient Diagnosis: _____

Auto Related? Y or N

Is Patient currently in Home Health? Y or N

Has Patient had PT this year: Y or N

Approximate # of visits: _____ (If Applicable)

Primary Insurance: _____ Plan Name: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: ____ / ____ / ____
(If Applicable)

Relationship (circle one) : Self Spouse Child Other: _____

Claims Address: _____

Insurance Phone #: _____

Secondary Insurance: _____ Plan Name: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: ____ / ____ / ____
(If Applicable)

Relationship (circle one) : Self Spouse Child Other: _____

Claims Address: _____

Insurance Phone #: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

I, the undersigned, do hereby agree and give my consent for Longevity PT & Wellness to furnish medical care and treatment to the patient named above considered necessary and proper in diagnosing or treating his/her physical condition.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I do hereby give my permission to LONGEVITY PT & WELLNESS to furnish my insurance carrier(s) any and all information pertaining to my medical records. (You have the right to refuse to sign this acknowledgement if you so choose).

Patient/Guardian Signature: _____ Date: _____

(Staff Only) Intake completed by: _____ Date: _____



PATIENT MEDICAL HISTORY

Patient Name: _____

Date of Surgery or injury: _____
(If Applicable)

Referring Physician: _____

Family Physician: _____

Height: ____ ft ____ in

Weight: _____ lbs (This information is required for insurance purposes)

Current Medication(s): _____

Current Pain Level (circle): 1 2 3 4 5 6 7 8 9 10

Have you had PT before? Y or N

Have you had any of the following medical or rehabilitative services for THIS INJURY/EPISODE?

YES NO

____ ____ Chiropractor
____ ____ EMG/NCV
____ ____ Massage Therapy
____ ____ Myelogram
____ ____ Occupational Therapy
____ ____ Physical Therapy
____ ____ Emergency Room Care

YES NO

____ ____ General Practitioner
____ ____ MRI
____ ____ Neurologist
____ ____ Orthopedist
____ ____ Podiatrist
____ ____ X-Ray
____ ____ CT Scan

Other: _____

Do you have or have you ever had any of the following? (Mark a check on either the yes or no column)

YES NO

____ ____ Asthma/Bronchitis
____ ____ Shortness of breath/Difficulty Breathing
____ ____ Angina/Chest pain
____ ____ Coronary Heart Disease
____ ____ Do you have a Pacemaker?
____ ____ High Blood Pressure
____ ____ Heart Attack/Surgery
____ ____ Stroke/TIA
____ ____ Congestive Heart Disease
____ ____ Blood clot/Emboli
____ ____ Epilepsy/Seizures
____ ____ Thyroid Disease/Goiter
____ ____ Anemia
____ ____ Infectious Diseases
____ ____ Diabetes
____ ____ Cancer or Chemo/Radiation
____ ____ Arthritis
____ ____ Osteoporosis
____ ____ Gout
____ ____ Sleeping Problems/Difficulties
____ ____ Emotional/Psychological Diagnosis

YES NO

____ ____ Severe/Frequent Headaches
____ ____ Emphysema
____ ____ Vision/Hearing Difficulties
____ ____ Numbness/Tingling
____ ____ Dizziness/Fainting
____ ____ Bowel/Bladder Problems
____ ____ Weakness
____ ____ Weight Loss/Energy Loss
____ ____ Hernia
____ ____ Varicose Veins
____ ____ Allergies
____ ____ Any Pins/Metal Implants?
____ ____ Joint Replacement Surgery
____ ____ Neck Injury/Surgery
____ ____ Shoulder Injury/Surgery
____ ____ Elbow Injury/Surgery
____ ____ Back Injury/Surgery
____ ____ Knee Injury/Surgery
____ ____ Leg/Ankle/Foot Injury/Surgery
____ ____ Are you pregnant?
____ ____ Do you use tobacco?

Patient/Guardian Signature: _____ Date: _____

COMMUNICATION CONSENT

By signing below, I consent to the following methods of communication from LONGEVITY PT & WELLNESS and their staff regarding my medical care and appointments:

By providing a telephone number and submitting the form you are consenting to be contacted by SMS text message from Longevity PT & Wellness. Message frequency may vary. Message & data rates may apply. Reply STOP to opt out of further messaging. Reply HELP for more information. No mobile or messaging consent information will be shared with third parties/affiliates for marketing/promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties. To review our Privacy Policy, please refer to our website or ask our office staff.

Please check which contact methods you consent to:

☐ Phone

☐ Text Messaging

☐ Email

Patient/Guardian Signature: _____

Date: _____

Insurance Assignment and Medical Records Release:

I, the undersigned, do hereby give my permission to LONGEVITY PT & WELLNESS, LLC to furnish my insurance carrier(s) any and all information pertaining to my medical records. I also authorize release of my personal health care information to the following individuals:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Patient/Guardian Signature: _____

Date: _____

CANCELLATION POLICY

We reserve the right to charge \$50.00 for a missed appointment without a 24 hour advanced notice or for failing to arrive for an appointment without notice. It is important to note that we pride ourselves in helping people get better. It is impossible to do so if you do not keep your appointments. Help us and you succeed by keeping your appointments.

Patient/Guardian Signature: _____

Date: _____

HIPPA PRIVACY NOTICE & PATIENT RIGHTS ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I also acknowledge that I have been given the opportunity to review my patient rights which includes treatment without discrimination or exclusion based on race, color, national origin, age, disability, sex, religion or any other protected status. I also understand that I have the right to be provided interpretation services, both verbal and in writing during my treatment.

I understand that I have the right to file a grievance with Longevity PT & Wellness Compliance Officer or with the U.S. Department of Health and Human Services, or Office of Civil Rights if I believe that Longevity PT & Wellness has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Patient's Name Printed: _____

Patient's or Responsible Parties Signature: _____ Date: _____

Responsible Parties Relationship to Patient: _____