



Greater Brunswick Physical Therapy

22 Lincoln Street
Brunswick, ME 04011
Phone: (207) 729-1164 Fax: (207) 725-0905

Intake Form

Date: _____

Therapist: _____

PATIENT INFORMATION

NAME: _____

PARENT (if a minor): _____

ADDRESS: _____

CITY: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

DATE OF BIRTH: _____ GENDER: _____

EMPLOYER: _____

E-MAIL ADDRESS: _____

REFERRING DOCTOR: _____

DOCTORS ADDRESS: _____

PHONE: _____

SOCIAL SECURITY#: _____

PRIMARY CARE DOCTOR: _____

PHONE: _____

HOW DID YOU LEARN ABOUT GREATER BRUNSWICK PHYSICAL THERAPY (check all that apply)

- PHYSICIAN FRIEND TELEPHONE BOOK FORMER PATIENT
- INTERNET NEWSPAPER INS COMPANY RECCOMENDATION
- OTHER: (please specify): _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY/ID: _____ GROUP: _____

SUBSCRIBERS NAME: _____

DOB: _____

SECONDARY INSURANCE: _____

POLICY/ID: _____ GROUP: _____

SUBSCRIBERS NAME: _____

DOB: _____

WORKER'S COMP/AUTO INSURANCE NAME: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE NUMBER: _____ ADJUSTER _____

EMPLOYER'S NAME AND ADDRESS _____

CLAIM NUMBER: _____ BADGE NUMBER: _____ DEPT. NUMBER _____

DATE OF INJURY: _____

ATTORNEY'S NAME ADDRESS AND PHONE _____

CONSENT FOR TREATMENT

I understand that I have been referred for rehabilitation treatment to Greater Brunswick Physical Therapy (GBPT). GBPT will design for me my individual treatment plan and I understand that I have the right to ask and have any questions answered prior to receiving treatment. This includes any risks or alternatives to the treatment plan that has been prescribed for me. By signing, I consent to have GBPT provide treatment under the direction prescribed by my referring provider or by my therapist.

Signed: _____

Dated: _____



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For ALL Patients

Please read carefully and sign below

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby assign payment directly to Greater Brunswick Physical Therapy any group benefits due to me for services rendered. I understand I am financially responsible for any balance remaining after payment of such benefits.

SUPPLIES: I also understand that I am financially responsible for all and any supplies that are given to me during the course of my treatment. Payment will be due on the day the supply was received.

RELEASE OF INFORMATION: I authorize the release of medical information, relative to treatment received, to the insurance company for payment of these services.

Signed: _____

Dated: _____

Printed Name: _____

For MEDICARE Patients

Please read and sign below

I have been notified by Greater Brunswick Physical Therapy that Medicare will cover physical therapy services at 80% of all approved charges, after which I am personally responsible for the remaining percentage along with my annual deductible (if it has not already been met). The remaining percentage may be covered if I have supplemental insurance. I have also been informed that Medicare has an annual outpatient physical therapy cap of \$1810.00 per calendar year.

Signed: _____

Dated: _____

Printed Name: _____

For MANAGED CARE Patients

Please read and sign below

I understand that it is my responsibility to have approval for physical therapy, from my insurance company prior to my initial physical therapy visit. If the insurance company denies payment for physical therapy on the basis a referral was not obtained, or I have exceeded the number of approved physical therapy visits, I am personally and fully responsible for payment of services rendered at Greater Brunswick Physical Therapy.

Signed: _____

Dated: _____

Printed Name: _____

Please remember that you are ultimately responsible for ensuring payment of physical therapy charges.



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RELEASE OF INFORMATION

I authorize **Greater Brunswick Physical Therapy** to release information regarding my care to those companies and /or individuals listed below unless otherwise indicated. This information may be in the form of typed or written notes, faxed information, billing information, or verbal discussions. (Please note: Number 1-4 is required if billing your physical therapy treatments to your insurance company.)

1. My referring physician.
2. My primary care physician (if different)
3. My insurance carrier (s)
4. My electronic billing clearing house.
5. My attorney's office (Name): _____
6. Others: _____

Signed: _____

Dated: _____

Printed Name: _____

I authorize **Greater Brunswick Physical Therapy** to discuss my scheduling of appointments at **Greater Brunswick Physical Therapy** with the following individuals:

May leave a message on my answering machine? (Yes / No)

Signed: _____

Dated: _____

Printed Name: _____

CANCELLATION/NO-SHOW POLICY

Our cancellation/no-show policy is designed to improve the quality of care of our present patients and allow us to see new patients who need services. Any combination of four cancellations and or no-shows will result in discharge from physical therapy. Your physician will be contacted to inform him/her of the reason for discharge. Additionally, if more than one appointment is missed due to no-shows, a **\$30.00** fee will be charged for each subsequent no-show. **This fee is not covered by insurance.**

I have read and understand the above policy.

Signed: _____

Dated: _____



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MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ INJURY DATE/ONSET: _____
CAUSE OF INJURY OR ONSET: _____ ARE YOU PRESENTLY WORKING: YES/NO
PRIMARY CARE PHYSICIAN'S NAME: _____ NEXT MD APPT: _____
WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

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? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED? YES / NO IF YES, WHEN? _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY FOR THIS CONDITION? (circle one) YES / NO

WHAT WAS DONE / WHAT WERE THE RESULTS: _____

HAVE YOU HAD PRIOR PHYSICAL 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: (PLEASE SEE BACK OF THIS SHEET)

ALLERGIES: (PLEASE SEE BACK OF THIS SHEET)

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> CURRENTLY PREGNANT |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> FAINTING | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> CANCER | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> LOW BLOOD PRESSURE |
| <input type="checkbox"/> SUBSTANCE ABUSE | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> METAL IMPLANTS |
| <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> HIGH BLOOD PRESSURE (<input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled) | | |
| <input type="checkbox"/> RECENT FALL(s) (_____ IN THE PAST 3 MTHS) | <input type="checkbox"/> INCONTINENCE | | |

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT

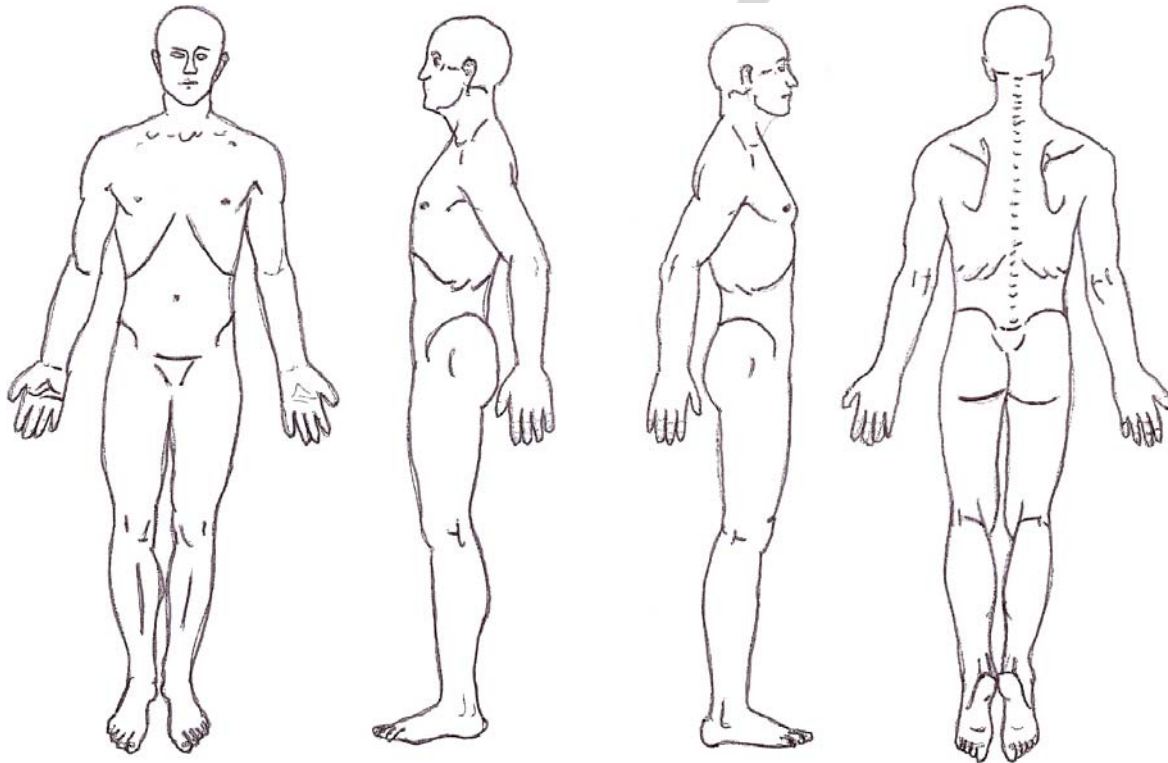
SIGNATURE OF THERAPIST

PAIN ASSESSMENT FORM

Name: _____ Date: _____

1. Initial Visit Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below.



3. Next to each area marked above, please note the intensity of pain

No Pain	Minimal	Tolerable, but Hinders activity	High – 50% of activities impaired	Extreme – most activities impaired	Unbearable					
0	1	2	3	4	5	6	7	8	9	10

Reviewed: _____