Three Trees Physical Therapy

285 Washington St, Suite 4, Easton MA 02356

p. 508-230-2323

Intake Form Today's Date: _____

Personal Data

*All fields below are required. Please confirm the information we have is correct, and either check the box to the right to confirm, or write in missing information/corrections/changes in the lines provided.

Name: _____ Date of Birth: _____

Social Security #: _____ Age: _____ Sex: _____

Address: _____

City/State/Zip: _____

Primary phone: _____ ❑ Cell ❑ Home

Secondary phone: _____ ❑ Cell ❑ Home

Email address: _____

Parent's Names (if under 18 years old):_____

Emergency Contact:_____ Relationship: _____

Emergency Contact Phone: _____ Email: _____

Insurance Information

Referred By: _____

Insurance: _____ Member ID: _____

Is patient the primary insured? ❑ Yes ❑ No

If no, name of primary insured:_____

COVID-19 Screen

Within the last 14 days, have you experienced any of the following symptoms?

Fever	❑ Yes ❑ No	Shortness of breath	❑ Yes ❑ No
Cough	❑ Yes ❑ No	Muscle aches	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No	Intestinal issues	❑ Yes ❑ No

I hereby certify that the information provided is true and accurate.

Signature:_____ Date:_____

Reason for Today's Visit (Please describe your chief complaint.)

_____

_____

When did this problem start? (if post surgical, date of surgery) _____

Have you had this problem before? ❑ Yes ❑ No

Is your injury related to a car accident? ❑ Yes ❑ No
Is your injury related to work? ❑ Yes ❑ No
Have you seen any of the following for your condition? ❑ Physical Therapist ❑ Chiropractor ❑ Orthopedic Surgeon
Has any imaging been done? ❑ Yes ❑ No

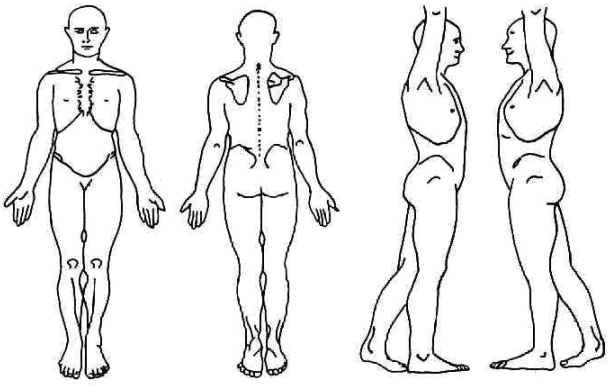
If imaging has been done, please describe what imaging (xrays, MRI, CT scan, etc.):

_____

What are your goals for physical therapy?

_____

Please indicate the location(s) of your pain on the diagram with XX marks:



- Please describe the pain:

  ❑ Dull ❑ Burning ❑ Numb ❑ Tingling ❑ Sharp

- How often does the pain occur?

  ❑ Constant ❑ Comes and Goes

- Does the pain radiate or travel? ❑ Yes ❑ No
- What makes the pain better? _____

  _____

- What makes the pain worse? _____

  _____

- Please indicate the severity of pain. Circle two numbers. The first number is how low the pain goes (when resting, taking meds, etc.). The second number is how high the pain goes when performing painful activities.

(0=no pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (10=worst pain ever)

- Please indicate what percent of normal function you feel you have currently.

(0% function) 0 – 10 – 20 – 30 – 40 – 50 – 60 – 70 – 80 – 90 – 100 (100% normal function)

Patient Health History

Please list all current medications, or submit as a separate list.

_____

_____

Please list any allergies. _____

Please list any past surgeries with dates.

_____

Please check off in the boxes below any health conditions which you had or currently have:'

	Yes		Yes
AIDS/HIV positive	❑	Heart disease	❑
Angina	❑	Kidney problems	❑
Asthma	❑	Liver disease	❑
Arthritis	❑	Memory problems	❑
Artificial joint	❑	Mental/emotional disorders	❑
Balance problems	❑	Migraines	❑
Breathing problems	❑	Osteoporosis	❑
Cancer	❑	Pacemaker	❑
Chemotherapy	❑	Pain in jaw	❑
COPD	❑	Prostate problems	❑
Diabetes	❑	Radiation treatment	❑
Dizziness	❑	Recent weight loss	❑
Emphysema	❑	Rheumatoid arthritis	❑
Fatigue	❑	Seizures	❑
Gout	❑	Shingles	❑
Headaches	❑	Steroid use – long term	❑
Heart attack	❑	Stroke	❑
High/low blood pressure	❑	Swelling of limbs	❑
High cholesterol	❑	Thyroid disease	❑
Hepatitis	❑	Tuberculosis	❑

Other illness/conditions not listed above ❑

Please describe: _____

_____

Height: _____ Weight: _____

I hearby certify that the information provided is true and accurate.

Patient Signature:_____ Date:_____

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Privacy Practices Notice (HIPPA) - Abbreviated

Three Trees Physical Therapy's policies related to the use and disclosure of private health information for treatment, payment, or healthcare operations.

As part of patient treatment, Three Trees Physical Therapy originates and maintains paper and/or electronic records describing patient contact information, federal and insurance identifiers, health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information is 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 physician certifications.

Should it become necessary to disclose patients' protected information to another health provider or third party payer for the above purposes, such as disclosure for these permitted uses, it may be transmitted via mail, telephone, fax and/or secure internet connection.

If the patient objects to these practices, they must submit their request for changes in the use of their protected information in writing. Receipt of such a request will be reviewed, but does not guarantee the ability of Three Trees Physical Therapy to comply. The patient will be notified of the result of the review in writing.

Three Trees Physical Therapy maintains a full Privacy Protection Policy, which may be viewed at any time, or a paper copy supplied upon request.

THREE TREES
PHYSICAL THERAPY

285 Washington St, Suite 4
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508-230-2323

Acknowledgment of Receipt of Privacy Practices

Three Trees Physical Therapy's policies related to the use and disclosure of private health information for treatment, payment, or healthcare operations.

I understand that under the Health Insurance Portability Act of 1996 ("HIPPA"), 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 physician certifications.

I have received a copy of Three Trees Physical Therapy's Privacy Practices, and understand they will maintain a more detailed version, which I may view and/or receive a paper copy of on request.

I agree any disputes regarding these privacy practices will be addressed in writing.

Patient Name: _____

Signature: _____ Date: _____
(or Legal Guardian if under 18 years old)

Office Use Only

An attempt was made to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so for the reasons documented below.

Date: _____ Initials: _____ Reason: _____

THREE TREES
PHYSICAL THERAPY
STRENGTH STABILITY GROWTH

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Office Policies and Informed Consent to Treat.

Patient Name: _____ Date of Birth: _____

Please read the following statements carefully and discuss any questions or concerns with the doctor before signing.

Insurance Billing/Payment

Three trees Physical Therapy will make every effort to verify insurance benefits, but it is ultimately my responsibility to determine benefit and authorization information before services are rendered. I understand that verification of benefits is not a guarantee of payment, and my insurance company makes the final determination of benefits upon receipt of each claim. If, after Three Trees Physical Therapy has submitted all necessary information, my insurance company refuses payment for a claim, the services rendered will then be my financial responsibility. If my insurance does not cover physical therapy care, I understand that payment is due at the time services are rendered.

Missed Appointment Fee

I understand that Three Trees Physical Therapy will charge $25 for any appointments that are missed and not rescheduled or cancelled within 24 hours of the scheduled time. I will be notified of the first missed appointment and not charged (one "grace" visit), then charged $25 for any and all missed appointments thereafter.

Consent to Treat

Since physical therapy responses to a specific treatment vary widely from person to person, it is not always possible to accurately predict your response to a certain exercise, modality or procedure. We are not able to guarantee precisely your reaction to exercise or treatment, nor can we guarantee treatment will help the condition you are seeking treatment for. I understand there are certain inherent risks involved with physical therapy treatment because I will be asked to exert effort and perform activities with increasing degrees of difficulty. Possible side effects include increasing your current pain level, aggravation to existing injury, or experiencing a new injury. If any activity causes increased pain or discomfort, I will stop the activity and notify my physical therapist immediately.

I understand I have the right to ask my physical therapist about the types of treatment planned based on my medical history, test results and symptoms, and may discuss with my physical therapist at any time the potential risks and benefits of any specific treatment. I understand I have the right to decline any portion of the treatment at any time during my treatment session.

Based on the above information, I hereby consent to cooperate and participate fully in the performance of physical therapy exercises, treatments and interventions, and comply with the plan of care as established. I understand the risks associated with participation in physical therapy as outlined to me, and I wish to proceed.

Patient or Guardian's Signature: _____ Date: _____