Jaworski Physical Therapy
Patient Intake Form

Last Name	First Name	MI

Home address	City	State	Zip Code

Phone number	Email address

Height	Weight	Gender	Birthday	SSN

Employer	Occupation	Work phone number

Emergency Contact	Phone number	Relationship

Referring Medical Provider	Phone number

Primary Care Doctor	Phone number

Self Referral

□Yes □No	If yes, may we send a copy of your notes to your doctor? □YES □NO

Briefly describe the problem for which you are seeking treatment:

_____

_____

When did this problem start or what was surgery date: _____

_____

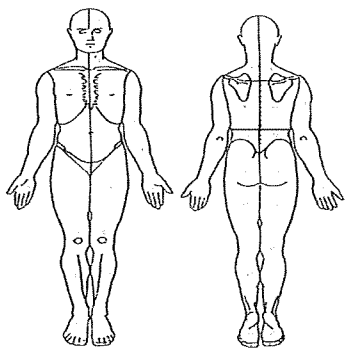
Other relevant surgeries: _____

_____

_____

_____

Problem is due to: □ Acute Injury
□ Chronic Issue □ Gradual Onset
□ Flare up of prior injury
□ Repetitive Motion
□ Other _____



Indicate areas of pain or concern on the diagram.

Current and Past Medical Conditions. Check all that apply.

□ Allergies	□ Circulation Problems	□ High Cholesterol	□ Osteoporosis
□ Aneurysm	□ Covid	□ HIV/AIDS	□ Parkinson's
□ Anxiety	□ Depression	□ Incontinence	□ Pregnant (current)
□ Arthritis	□ Diabetes	□ Joint Replacement	□ Rash (current)
□ Asthma	□ Dizziness	□ Kidney Problems	□ Rheumatoid Arthritis
□ Autoimmune disease	□ Emphysema/COPD	□ Low BP	□ Seizure Disorder
□ Back Pain	□ Fibromyalgia	□ Lupus	□ Sleep Apnea
□ Balance-off or Falls	□ Fractures	□ Metal implants	□ Smoker
□ Blood clots	□ Gallbladder issue	□ Migraines	□ Speech Problems
□ Cancer	□ Headaches	□ MRSA	□ Stroke
□ Cardiac-Defibrillator	□ Head injury	□ Multiple Sclerosis	□ TMJ
□ Cardiac-Pacemaker	□ Hearing loss	□ Neck Pain	□ Tuberculosis
□ Cardiac conditions	□ Hepatitis	□ Obesity	□ Thyroid Problems
□ Chemical Dependency	□ High BP	□ Open Wound (now)	□ Vision Problems

Additional medical/healthcare information: circle appropriate response

1. Do you have anyone coming into your home to assist you with personal care? YES or NO
2. Are you currently living in a Skilled nursing facility/rehabilitation center? YES or NO
3. Have you received Physical Therapy, Occupational Therapy or Chiropractic care since the first of this year? YES or NO If yes, when did therapy end? _____

AUTHORIZATIONS: Read and sign, initial or indicate yes/no to information below

1. Consent/Authorization for Treatment: I know that I am suffering from a condition(s) requiring Physical Therapy and/or Athletic Training. I hereby voluntarily consent to such treatment and procedures to be performed by employees of Jaworski Physical Therapy, Inc. YES or NO

2. Phone messages: I give permission for Jaworski Physical Therapy, Inc to leave a message (verbal or text) at the phone number I provided. YES or NO

3. Photographs: I consent for Jaworski Physical Therapy, Inc employees to take a photograph of me only for the purpose of use in my medical chart and that will not be disclosed for any reason without additional permission from me. YES or NO

4. Medical Benefits: 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. Initial: _____

5. 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. Initial: _____

I authorize employees of Jaworski Physical Therapy, Inc to discuss my health information with the following person(s): _____
_____

By signing this consent, I understand and acknowledge that I have reviewed the "Privacy Notice" before signing this consent.

Patient's Signature: _____ Date: _____

Parent Signature (for minor patient): _____

Witness: _____ Date: _____
(office use only)

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.

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.

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 _____ DOB _____ Date _____