Master Intake Packet

ProActive
REHABILITATION & WELLNESS

1. Insert Your Full Name

First _____ Last _____

2. Tell us a little bit about what's going on.

What's going on?

_____

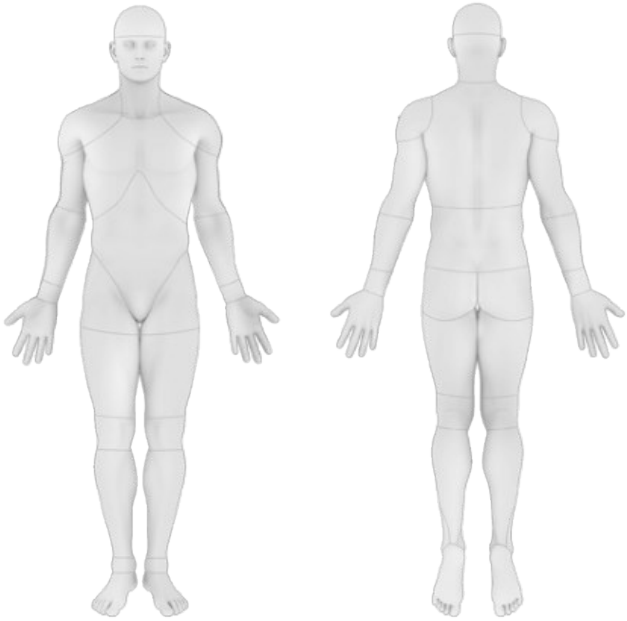
_____

How is this affecting your day-to-day life?

_____

_____

3. Please indicate where you are experiencing pain or limitations



Comments

_____

4. Please enter the date or onset of your symptoms

Date of onset:

_____

How did this start?

_____

_____

5. What are your main goals for treatment?

Goal 1

Goal 2

Goal 3

6. Do you have any expectations for treatment?

What do you hope to receive through therapy?

How do you see therapy helping you?

7. Enter Your Address Including City, State, & Zip Code

Address | City | State | Zip/Postal

8. Contact information

Mobile Phone

Is text message ok?

Alternate/LandLine | Email Address

When is the best time to call you?

- ☐ Morning (between 9:00-11:30 am)
- ☐ Lunch (between 11:30am-1:30pm)
- ☐ Afternoon (1:30-5:00pm)

9. Enter Your Date of Birth & Identification

Date of Birth

Social Security

10. Emergency Contact

Emergency Contact Name | Phone Number

Relationship (example: spouse, mother, friend, etc.)

11. How did you hear about us?

- Social Medial Ads
- Google Ads
- Physician/Doctor
- Sign
- Other

If Other, Explain:

12. Insurance Information Please include the full policy/membership ID in the space(s) marked below. If you are a military dependent, please provide the Sponsor's ID number.

Primary Insurance Company | Phone

Policy Number/Subscriber ID | Group Number (if applicable)

Subscriber Name (Primary Insured) | Subscriber' Date of Birth

Secondary Insurance | Policy Number/Subscriber ID

Secondary insurance Subscriber name

13. Physician Information

Physician or Doctor Name | Office Phone

Name of Practice or Medical Group

Address | City | State | Zip/Postal

I certify that the information provided is complete, true, and accurate to the best of my knowledge.

Signature | Date

14. Please list any past surgeries & their dates

15. Please list any adverse reactions or allergies to medicines or foods

16. Please tell us if you or an immediate family member have been diagnosed or treated for these conditions? If you select an option, please indicate whether it is yourself or a family member.

- ☐ Surgical implant
- ☐ Kidney disease/stones
- ☐ Pacemaker
- ☐ Heart Problems/Cardiac Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Chest Pain
- ☐ Ulcers
- ☐ Vascular Disease
- ☐ Osteoporosis
- ☐ High Blood Pressure
- ☐ Previous Fractures
- ☐ High Cholesterol
- ☐ Arthritis/Gout
- ☐ Shortness of Breath
- ☐ Rheumatoid Arthritis
- ☐ Asthma
- ☐ Lupus
- ☐ Sleep Apnea
- ☐ Other Breathing Problem
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Stroke/TIA
- ☐ Hypoglycemia
- ☐ Headaches
- ☐ Cancer
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Multiple Sclerosis
- ☐ Anemia
- ☐ Guillain Barre
- ☐ Thinning of Blood
- ☐ Immune System Compromise
- ☐ Blood Clots Infection
- ☐ Anxiety/Depression
- ☐ Substance Abuse

Comments (optional)

17. Please Check All of the Following That Apply to You and Provide Explanation as Needed

☐ Are you allergic to anything that touches your skin (e.g. Latex or tape?)

_____

☐ Have you had any illness in the last 3 weeks (e.g. influenza, bladder infection)

_____

☐ Have you recently had fever, chills or night sweats?

_____

☐ Have you had any recent changes in your bowel or bladder habits (difficulty starting urination, urinary frequency, loss of bowel or bladder control?)

_____

☐ Have you had any recent weakness or sense of fatigue?

_____

☐ Do you drink alcohol? If yes, how much?

_____

☐ Do you have hypersensitivity to heat or cold?

_____

☐ Do you have any open wounds/sores or rashes?

_____

☐ Have you noticed any lumps or thickening of your skin or muscle?

_____

☐ Is your weight stable (not gaining or losing more than a few pounds?)

_____

☐ Have you had any recent headache, nausea/vomiting, ringing in the ears, or vision changes?

_____

☐ Have you had an organ transplant?

_____

☐ Have you fallen in the last 6 months? If yes, how many times?

_____

☐ Have you had any physical therapy, anywhere, for any condition in the past 12 months? If yes, when and where?

_____

☐ Is there any chance that you might be pregnant?

_____

☐ Have you noticed any moles or warts that have changed in appearance?

_____

☐ Are you following a special diet prescribed by a doctor?

_____

☐ Have you had any recent lightheadedness, dizziness, feeling like you might faint, or loss of consciousness?

_____

☐ Do you use tobacco? If yes, how much?

_____

☐ Do you have difficulty getting up from a chair without using your arms?

_____

☐ Has any doctor ever told you that you should limit your activities?

_____

Comments (optional)

_____

18. Please list any medications, prescriptions, or over-the-counter medications that you are presently taking.

Medication	Medication	Dose	Frequency	Reason

19. Rate Your Level on a scale of 1 (lowest) to 10 (highest/worst)

Current Pain Level

_____

Pain Level With Movement

Function

20. Is there anything else that we didn't ask that you think we should know about?

I certify that the above information accurately describes my medical history and that I will notify my PT immediately of any changes in my medical history.

Signature Date

Let's be honest, everyone hates attendance policies. We hate giving them out, and you all hate signing them and feeling like you're being held hostage by a policy that's more designed around the clinic's convenience rather than your own. But here's the deal: if you aren't committed to your therapy, wellness, or performance program, you likely won't experience the benefits, improvement, or pain relief you want and need. You get out what you put in. We promise to show up, 100%, for you. That being said, this isn't a one-way street. It requires that you make some commitments as well; commitments to us & our programs, and commitments to yourself: During your first visit, we will discuss treatment options and set goals with you. We will be flexible and make every effort to schedule appointments at times that are convenient for you. We can also give you a printout to remind you of your appointments. Here are some basic commitments we expect from all of our patients and clients: 1) Please arrive on time for your appointment so that you may be given the full benefit of your scheduled treatment. 2) Please plan to attend every scheduled therapy appointment. We realize that at times, this may not be possible, and you may need to reschedule your appointment. Please note that we ask you to call the office at least 24 hours before the scheduled appointment time. 3) If you call to reschedule an appointment with less than 24-hour notice, it is considered a Same Day cancellation. Same Day Cancellations may result in discontinuation of services, if they occur regularly. 4) Failure to show for an appointment or calling to cancel your appointment after the time your appointment was scheduled, is considered a "No Show". A "No Show" will result in a $15 charge. This charge covers the administrative costs of rescheduling an appointment and adjusting the schedule. Two "No Show" appointments will result in a discontinuation of your therapy services. Multiple Same Day Cancellations or the inability to attend regularly scheduled appointments may result in discontinuation of therapy services at the discretion of the clinician. If your services are discontinued, your referring physician/provider will be notified and you will be required to get a new referral to resume physical therapy. We thank you for choosing ProActive Rehabilitation & Wellness, LLC. We are looking forward to partnering with you to help you reach your goals. Your therapist will be happy to discuss this policy with you if you have any questions or concerns, The Staff at ProActive Rehabilitation & Wellness

Signature Date

Consent for Treatment & Provision of Services: I have a condition requiring therapy intervention, wellness & health promotion, or performance program participation, and consent to the delivery of such care and/or services. In order to improve my condition, I consent to enter ProActive Rehabilitation & Wellness programs for evaluation and treatment. I request and authorize the licensed staff of ProActive Rehabilitation & Wellness, LLC to render treatment, and to perform appropriate procedures that my referring provider may deem reasonable and necessary for my diagnosis. I understand that my clinical care and treatment may be provided by a licensed clinician, either a licensed therapist or assistant. I am aware that there are certain risks involved with any therapy, wellness & health promotion, and/or performance program. Every effort is made to minimize my risk by continuous assessment of my condition throughout my participation in the program. I will inform my therapist or clinician of any changes in my medical condition, or medications, as they may necessitate change in my individualized program. I will stop any procedure or activity and inform my therapist or clinician of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment or session.

_____ _____

Signature Date

Privacy Notice Acknowledgement: As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of ProActive Rehabilitation & Wellness LLC's "Notice of Privacy Practices". I understand that I am responsible to read this Notice and notify Proactive Rehabilitation & Wellness, LLC, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. ProActive Rehabilitation & Wellness, LLC has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times. I am aware that ProActive Rehabilitation & Wellness, LLC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. ProActive Rehabilitation & Wellness, LLC will provide me with a copy of its most recent Notice upon my request.

_____ _____

Signature Date

Requirement to Provide Proof of Current Insurance and Obtain Referral: I understand that it is my responsibility to provide ProActive Rehabilitation & Wellness with a copy of my current insurance card(s) and to obtain a referral from my Primary Care Physician's office (if required by my insurance or by state law). If I do not have insurance, I will be considered a Self-Pay patient and I am financially responsible for the total amount of the services provided. I will notify ProActive Rehabilitation & Wellness immediately upon any changes in my insurance.

_____ _____

Signature Date

Insurance Waiver: I understand that if I do not have a copy of a current insurance card and valid referral, if required, ProActive Rehabilitation is not obligated to see me, but if I still wish to be seen, I can be seen as a "Self-Pay" patient. I agree that neither Proactive Rehabilitation & Wellness nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance.

Signature Date

Payment & Balances: Co-payment is due on each day services are rendered. There is a $35.00 charge for all returned checks to cover administrative costs. When an account has received two returned checks, it will automatically be placed on a "cash" only status. For your convenience, we accept cash, checks, credit cards and debit cards. In the event that a patient balance remains open for 180 days, that account will be placed in collections. A collections fee of 35% of the outstanding balance will be charged for the administrative cost of collecting outstanding balances.

Signature Date

Assignment of Benefits: I hereby authorize and assign all payments and/or insurance benefits for therapy services rendered to the patient, directly to ProActive Rehabilitation & Wellness, LLC. I hereby authorize ProActive Rehabilitation & Wellness to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

Signature Date

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. For pool/aquatic therapy visits, pool attire is required.

Signature Date

Adult Supervision: Those under the age of 16 receiving treatment at our facility must be accompanied by a parent or legal guardian during each service appointment.

Signature Date

Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan.

Signature Date

Optional Media/Marketing Consent: I authorize ProActive Rehabilitation & Wellness LLC and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photographs, videos, medical and physical therapy records, and/or audio recordings for the following purposes: Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on ProActive Rehabilitation & Wellness, LLC's website and social media sites. Use in news releases or stories, including television, newspaper, or radio broadcasts. Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites. I understand that my name & personal contact information will never be disclosed unless prior written authorization is obtained, and that my identity will be anonymized. I provide my authorization knowing that: The Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws. Signing this authorization is voluntary. I have the right to refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization. I understand that I can revoke or cancel this authorization at any time by sending written notice to: ProActive Rehabilitation & Wellness, LLC 2103 Reedale Ave. Augusta, GA 30906 If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization. I am entitled to receive a copy of this Authorization upon request. Unless I revoke this authorization, it will expire 30 months from the date signed below.

_____ _____

Signature Date