



14 Mariaville Rd, Bldg 1
Ellsworth, ME 04605
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

130 Perry Rd
Bangor, ME 04401
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

4 Gendron Dr, Unit 5
Lewiston, ME 04240
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

Patient Intake and Demographic Sheet

PATIENT DEMOGRAPHICS:

Patient Name: _____ Mobile/Home Phone: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____ Age: _____ Sex: _____ Marital Status: _____

Family member holding the policy: _____ Their DOB: _____

Email Address: _____ Work phone: _____

Who is your primary care physician: _____

*How did you hear about our facility? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for UBE Physical Therapy. I recognize that I must give my written authorization to UBE to release any of my protected healthcare information in instances beyond purposes for treatment, payment, certain healthcare operations, or in instances required or permitted by law.

Patient Name: _____
(Please Print)

Patient or Authorized Representative: _____ Date: _____
(Signature)

By signing your name electronically, you are agreeing that your electronic signature is equivalent to your manual signature.

INFORMED CONSENT FOR CARE AND TREATMENT

UBE Physical Therapy and its employees, volunteers, and students use a variety of procedures and modalities to help improve an individual's function. As with all forms of medical treatment, there are benefits and risks involved with PT and can vary widely from person to person.

You have the right to ask your PT what type of treatment is planned for you. You may discuss the potential risks and benefits of treatment and the outcomes of choosing not to receive treatment. You have the right to stop treatment at any time.

I acknowledge that my treatment program has been explained and all of my questions have been answered to my satisfaction. I understand the risks associated with treatment, and I wish to proceed.

I, the undersigned, do hereby agree and give my consent for UBE Physical Therapy to furnish medical treatment to (please PRINT name).

Patient/guardian signature: _____ Date: _____

By signing your name electronically, you are agreeing that your electronic signature is equivalent to your manual signature.



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Physical Therapy Chart Audit -- Detailed

Patient Name: _____ **Date of Birth:** _____

Chart Number: _____

Treating Therapist(s): Cat Kenney Ryan Davis Alyssa Bosse Nate Caruso

Audited by: _____ **Case Open Date:** _____

OBJECTIVE	RESULTS	COMMENT: DATE AND ACTION
Medicare patient?	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
Script/ Order/ Referral?	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
Signed HIPAA/FPS?	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
PMH/PQRS	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
INITIAL EVALUATION/ PLAN OF CARE		
Initial Eval Date	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Report signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	
UPDATED NOTES		
Progress every 10 visits/ 30 days	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	Status:
Progress every 10 visits/ 30 days	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	Status:
Progress every 10 visits/ 30 days	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	Status:
Progress every 10 visits/ 30 days	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	Status:
Progress every 10 visits/ 30 days	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	Status:
Progress every 10 visits/ 30 days	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	Duration:
Signed by the physician/NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	Status:
CAP EXCEPTION		
KX Modifier Used? (check last date seen in Accounting)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	
Justification Statement? (Anywhere in Documentation)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	
DISCHARGE NOTE		
Discharge Note completed	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
Signed by the physician/ NPP?	<input type="checkbox"/> YES/ NO* <input type="checkbox"/>	
TREATMENT ENCOUNTER NOTE		
Daily Note for each visit scheduled?	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
Each treatment billed in accounting?	<input type="checkbox"/> YES/ NO <input type="checkbox"/>	
CASE STATUS		
Case Locked (ALL items in chart and locked—check under accounting and 30 reminder)		

*Please fax any unsigned Initial Evaluations, Updated Plan of Cares and / or Discharge Notes to physician / NPP signature.



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PAST MEDICAL HISTORY

Name: _____ Birth Date: _____

What are we seeing you for? _____

Accident/injury date: _____ Have you had surgery for this injury? YES NO

Type of Surgery: _____ Surgeon: _____ Restrictions? YES NO

*Current level of pain between 0-10 (0 being no pain, 10 being pain for ER care) _____ *

Are you currently taking any prescription or non-prescription medications? YES NO

List Medications: _____

Have you had any of the following medical and rehabilitative services for this injury or episode?

	YES	NO		YES	NO
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>
X-rays	<input type="checkbox"/>	<input type="checkbox"/>	MRI	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NVC	<input type="checkbox"/>	<input type="checkbox"/>	CT Scan	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Do you now have or have you EVER had any of the following:

	YES	NO		YES	NO
Asthma, bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Vision/hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Blood clot/emboli	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Any pins/metal implants	<input type="checkbox"/>	<input type="checkbox"/>
Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/psychological problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or chemotherapy/radiation	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/bladder dysfunction	<input type="checkbox"/>	<input type="checkbox"/>

Are you aware of what your diagnosis is? YES NO

Based upon your awareness, what are your expectations/goals while in this program?

How many times have you fallen in the last 12 months? _____ Did you injure yourself with the falls? YES NO. How did you fall? _____

Do you feel as though your weight is a problem? YES NO. If yes, have you talked with your PCP regarding this concern? _____



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FINANCIAL POLICY STATEMENT

- I. We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered.
- II. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.
- III. If your account balance is not paid in full within 60 days of receiving your first patient statement, the entire account balance shall be subject to a monthly finance charge of 1.00% and monthly costs of rebilling/account maintenance charges of \$8.00. These rates and charges are subject to change upon written notice 30 days in advance of changes.
- IV. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to UBE Physical Therapy.
- V. If any account balances should be placed with a collection agency or attorney for collection, the patient agrees to pay all costs of collection, including court costs, collection agency fees and/or reasonable attorney fees
- VI. The above does not apply for those patients that are considered WC. However, be advised if you claim Workers Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
- VII. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.
- VIII. I authorize that the payment of my insurance benefits be made directly to UBE Physical Therapy for any services that are reimbursable by my insurance company, if I have one.
- IX. UBE Physical Therapy has a returned check fee of \$40.

ESTIMATED INSURANCE BENEFITS:

Estimated patient payment: Copayment: _____ Coinsurance: _____

Notes: _____

NOTE: Estimated coverage information is provided as a courtesy to our patients but is not intended to release them from responsibility for their account balance. The above information has been read and explained to me.

 Patient/Guardian/Responsible Party
By signing your name electronically, you are agreeing that your electronic signature is equivalent to your manual signature.

 Date

 Center Representative/Witness
By signing your name electronically, you are agreeing that your electronic signature is equivalent to your manual signature.

 Date

 Initials **Cancellations/No Shows:** All cancellations must be made 24 hours prior to the scheduled appointment. Any appointment cancelled with less than 24 hours notice may be subject to a \$25 fee. Failing to arrive for your scheduled appointment without prior notice will result in a charge of \$50.

 Initials **Home Health:** I certify that I am not currently receiving Home Health services. I understand that it is the Home Health agency's responsibility to provide therapy services. I understand that if I am currently receiving or will receive Home Health services, it is my responsibility to pay for therapy services provided by UBE Physical Therapy.

 Initials **Dry Needling Charge:** I am aware that dry needling is a self-pay service and will not be covered by my insurance, and therefore, should I choose to receive this service I will be charged a \$5 dry needling fee per visit.