UBE PHYSICAL THERAPY AND PERFORMANCE

14 Mariaville Rd, Bldg 1
Ellsworth, ME 04605
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4 Gendron Dr, Unit 5
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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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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	☐	☐	Chiropractor	☐	☐
Massage Therapy	☐	☐	Occupational Therapy	☐	☐
Neurologist	☐	☐	Orthopedist	☐	☐
X-rays	☐	☐	MRI	☐	☐
EMG/NVC	☐	☐	CT Scan	☐	☐

Other:_____

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

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

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

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

_____ 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.