



Patient Information

Name (First MI Last):	Date of Birth:	Gender:
Mailing Address:	Social Security #:	
Physical Address (if different):	Referring Doctor:	
City:	Marital Status (M, S, D, W):	
State, Zip:	Employer:	
Home Phone:	Emergency Contact and relationship:	
Work Phone:	Emergency Phone:	
Cell Phone:	E-mail Address:	

Insurance Information

Health Insurance: Please provide health insurance card to the receptionist to copy, and, if you are not the primary insured person, please fill out the primary person information below.

Name of Primary person on insurance:		Name of Primary person on secondary insurance:	
Date of Birth:	Gender:	Date of Birth:	Gender:
Member ID #:		Member ID #:	
Insured's Employer:		Insured's Employer:	

All other types of insurance (Auto, Worker's Comp): Please fill out applicable fields.

Insurance Co:	Insurance Co billing street address:
Policy ID#:	Insurance Co billing state and zip code:
Claim #:	Employer Name and Phone (WC only):
Adjuster's Name and Phone Number:	
Case Manager's Name and Phone Number:	

Confidential Medical History/Evaluation



Name: _____ Date: _____

Is this injury: Work related? Yes _____ No _____ Auto Accident? Yes _____ No _____

Date of injury: _____

Chief Complaint(s): _____

Current Symptoms (please circle): Pain Numbness Stiffness Weakness Difficulty Walking Balance

Condition: New Acute Chronic

List any/all medications you are currently taking: _____

List any surgeries: _____

Circle any diagnostic services for this injury? X-Ray MRI CT scan EMG NCV Other: _____

Any other care received for this problem: _____

Do you have any of the following?

	Yes	No
Asthma, Bronchitis or Emphysema		
Shortness of Breath/Chest Pain		
Coronary Heart Disease		
Pacemaker		
High Blood Pressure		
Heart Attack/Surgery		
Stroke/TIA		
Blood Clot/Emboli		
Epilepsy/Seizures		
Thyroid Trouble/Goiter		
Anemia		
Infectious Disease		
Diabetes		
Cancer or Chemo/Radiation		
Arthritis/Swollen Joints		
Osteoporosis		
Varicose Veins		
Gout		
Sleeping Difficulties		
Emotional/Psychological Problems		
Bowel or Bladder Problems		
Severe/Frequent Headaches		
Vision/Hearing Difficulties		
Dizziness or Faintness		
Are you pregnant?		
Smoking	Daily _____	Weekly _____
Alcohol Consumption	Daily _____	Weekly _____

Do you have pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending				
Care for Infirm Family				
Carrying Groceries				
Sit to Stand				
Climb Stairs				
Driving				
Extended Computer Use				
Feeding Self				
Household Chores				
Kneeling				
Lift Children				
Lifting				
Pet Care				
Reading (Concentration)				
Bathing				
Dressing				
Shaving				
Sexual Activities				
Sleep				
Sitting (Prolonged)				
Standing (Prolonged)				
Walking				
Yard Work				
Sports				
Recreational Activities				
Exercise	Daily _____	Weekly _____		

Other Medical Conditions _____

Are you aware of your Diagnosis? YES _____ NO _____

Are you aware of your Prognosis? YES _____ NO _____



Consent for Treatment, Assignment of Benefits, Financial Policies

- **Consent for Treatment**

I authorize In Touch Therapy to provide medical treatment to me and or my dependent.

- **Assignment of Benefits**

I request that payment of authorized Medicare or applicable private insurance benefits be paid directly to In Touch Therapy for services provided under their care.

- **Release of Medical Information**

I authorize In Touch Therapy to release necessary medical information to my insurance company, its agents, or any third party payor in order for payable benefits for these services to be determined.

- **Financial Responsibility**

I understand that co-pays are due at the time of service.

I understand that In Touch Therapy will file my insurance as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand that if my account is referred to a collection agency or attorney, I will be responsible for all expenses and up to 33.33% of collection costs.

- **Referrals/Authorizations**

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. I understand that if I do not have a referral, no services will be rendered until the referral is received or until I sign a waiver acknowledging acceptance of financial responsibility. Payment in full will be required on the day of your appointment.

- **Medicare Patients**

I understand that I am responsible for Medicare co-insurance. If I have a secondary insurance that does not pay the full co-insurance amount, I understand that I will be billed for and agree to pay the remaining amount due.

- **Missed Appointments**

We require at least 24 hours notice if you must cancel an appointment. Failure to do so may result in a \$15 "no show" fee.

- **Returned Checks**

Our office will charge \$25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

Signature of Patient or Responsible Party

Date