PATIENT INTAKE INFORMATION

Welcome to Limitless Physical Therapy. Our Physical Therapists and staff take pride in providing you individualized care and impeccable customer service. To best serve you, we need to gather some information about you. If you have any questions, please ask.

Name: _____ Date: _____

Height: _____ Weight: _____

WHAT BRINGS YOU IN

Injury/Condition: _____ What date did your symptoms begin? _____

What caused your injury/condition? _____

Have you seen another provider for this problem? ☐ **YES** ☐ **NO** If yes, when? _____

Have you had imaging done for this problem? ☐ **YES** ☐ **NO**

If yes, what kind? _____

Have had any surgery or procedure done to address this problem? **YES** ☐ **NO** ☐

If yes, describe: _____

TELL US ABOUT YOUR PAIN

My pain is like (Circle all that apply):

Numbness Sharp Dull Achy

Burning Tingling Throbbing

I feel this pain (Circle all that apply):

Constantly Intermittently Inconsistently

Rate your pain level 0-10 (0 = No pain; 10 = Severe pain):

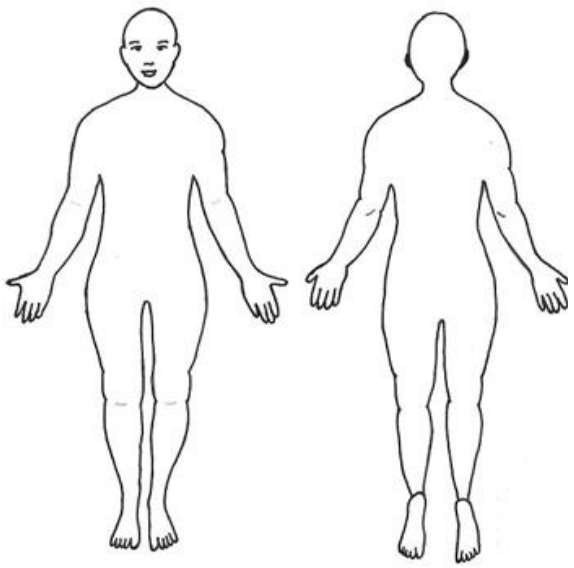
Currently: _____ At its best: _____ At its worst: _____

What movements or activities make your condition worse?

_____

_____

Mark where you have pain



GOALS

List 3 activities you are limited in currently and rate the difficulty 0 – 10 (0 = Cannot do at all; 10 = No difficulty):

1. _____ Difficulty: _____
2. _____ Difficulty: _____
3. _____ Difficulty: _____

HEALTH HISTORY

Please list all medications you are currently taking (If more than 3 ask us for a med sheet): _____

_____

Is this injury the result of a fall? ☐ **YES** ☐ **NO**

Have you fallen in the past year? ☐ **YES** ☐ **NO** If yes, how many times? _____

Have you recently had any of the following? (Circle all that apply):

Bladder Difficulties	Bowel Difficulties	Breathing Difficulties	Insomnia
Weakness	Change in Vision	Nausea/Vomiting	Weight Loss
Fatigue	Fever/Chills/Sweats	Pain at Night	Pregnancy

Do you currently have, or have you had any of the following? (Circle all that apply):

Allergies/Skin Sensitivities	Anxiety	Asthma/Breathing Problems	Autoimmune Deficiency
Cancer	Circulation Problems	Depression	Diabetes
Easy Bruising/Bleeding	Fainting	Fractures	Heart Problems
Hepatitis	High Blood Pressure	Indigestion/Heartburn	Kidney Disease
Leg/Ankle Swelling	Loss of Consciousness	Lung Disease	Metal Implant
Motor Vehicle Accident	Multiple Sclerosis	Osteoporosis/Osteopenia	Pacemaker
Smoking	Sprains/Strains	Stroke	Surgeries
Thyroid Problems	Urinary Problems/Infections		

At the current time would you rate your overall health as (Circle one):

Excellent Very Good Good Fair Poor

PERSONAL INFORMATION

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ DOB: _____ Gender: ☐ **M** ☐ **F**

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Ph#:_____ **MAY WE LEAVE A DETAILED MESSAGE? ☐ YES ☐ NO**

Cell Ph#: _____ **MAY WE LEAVE A DETAILED MESSAGE? ☐ YES ☐ NO**

Work Ph#: _____ **MAY WE LEAVE A DETAILED MESSAGE? ☐ YES ☐ NO**

Email: _____

By marking "Yes" to allow us to leave detailed messages, you acknowledge that these may include personal information

I prefer appointment reminders via: ☐ Text ☐ Email ☐ Phone Call

If text, my cell carrier is: _____ (Please note that standard text messaging rates may apply)

Emergency Contact: _____ Ph #: _____ Relationship: _____

Physician's Name: _____ Clinic: _____

Other Current Healthcare Provider: _____ Clinic: _____

How did you hear about us?

☐ Referring Provider ☐ Friend/Family ☐ Radio

☐ Facebook ☐ Online ☐ Other _____

AUTO/WORK RELATED ACCIDENTS

Is this an auto related injury? ☐ **YES** ☐ **NO**

Claim#: _____ State where accident/injury occurred: _____

Adjustor's Name: _____ Phone#: _____

Is this a work-related injury? ☐ **YES** ☐ **NO**

Claim#: _____

Adjustor's Name: _____ Phone#: _____

Employer: _____ Employer phone#: _____

Employer Address: _____

MEDICAL INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name: _____

Are you the primary subscriber on the plan? ☐ **YES** ☐ **NO**

Member ID#: _____ Group #: _____ Policy #: _____

If you are **NOT** the primary subscriber, please complete:

Subscriber (primary on plan) exactly as it appears on card: _____

Subscriber's DOB: _____ Subscriber Gender: ☐ **M** ☐ **F** Subscriber Ph#: _____

Subscriber's Address: _____

Your SECONDARY Insurance Company's Name: _____

Are you the primary subscriber on the plan? ☐ **YES** ☐ **NO**

Member ID#: _____ Group #: _____ Policy #: _____

If you are **NOT** the primary subscriber, please complete:

Subscriber (primary on plan) exactly as it appears on card: _____

Subscriber's DOB: _____ Subscriber Gender: ☐ **M** ☐ **F** Subscriber Ph#: _____

Subscriber's Address: _____

If responsible party is someone other than yourself or the subscriber, please provide the following:

Name: _____ Relationship to patient: _____ Responsible Party's DOB: _____

Ph#: _____ Address: _____

Do you voluntarily consent to evaluation and treatment by Limitless Physical Therapy? ☐ **YES** ☐ **NO**

You have the right to decline any procedures after discussing the risks and benefits with your physical therapist.

Were you offered a copy of our HIPAA-Privacy Policy? ☐ **YES** ☐ **NO**

Additional copies can be made available to you upon request.

Please note: Phone calls to the main clinic line (541) 654-0274 (Eugene) or (541) 704-7770 (Albany), faxes to the clinic fax number (541) 228-9121 (Eugene) or (541) 704-7773 (Albany), and Keet are the only secure means to contact Limitless Physical Therapy. If you choose to contact the clinic or physical therapist via other means, including but not limited to Facebook message, email, or personal phone number, your personal information cannot be secured.

LIMITLESS PHYSICAL THERAPY FINANCIAL AGREEMENT

PLEASE CAREFULLY READ EACH ITEM BELOW AND SIGN ACKNOWLEDGING THAT YOU HAVE READ, UNDERSTAND, AND AGREE.
(You may return to the front desk for assistance from our Customer Service Specialists if you have any questions)

We request 24 hours' notice when cancelling appointments. If you fail to provide 24 hours' notice you will be charged a $40.00 fee.

You authorize Limitless Physical Therapy to communicate with your insurance company in order to collect payment for the services provided to you unless you have chosen to pay for services out of pocket. It is your responsibility to provide your insurance information to our office prior to receiving treatment. As a courtesy, Limitless Physical Therapy, verifies your benefits with your insurance company. The estimated financial responsibility provided after benefit verification is not a guarantee of benefits or payment. Coverage is subject to the terms of your insurance plan.

It is our policy that payment is due at the time of service unless other financial arrangements are made. We require all deductibles, copays and/or coinsurance payments at the beginning of each visit. You will be billed for any outstanding balances. At the conclusion of your treatment with us, if there is a credit, you will be provided a refund once all claims have processed with your insurance company.

If you have a payment agreement with Limitless Physical Therapy and you fail to honor the payment schedule, including declined payments, a $30 fee will be applied to your balance. Should failure to pay occur twice, your payment agreement will be canceled, and your account may be forwarded for collection review.

It is your responsibility to ensure funds are available for all payments made. If Limitless Physical Therapy is penalized for processing a payment with insufficient funds, any fees related to the failed payment will be applied to your account.

Failure to pay may result in further action necessary to collect outstanding balances. If your account is forwarded to a collection agency for assistance, a $30 fee will be applied to your balance.

At Limitless Physical Therapy, our goal is to assist you in a successful recovery. We ask that you communicate with us should you face any of the circumstances as above and we will do our best to work with you while ensuring our practice can continue providing an outstanding service and experience for others in the community.

Signature: _____ Date: _____

Printed name: _____

Consent to Share Personal Health Information (Optional)

I, _____, hereby consent for Limitless Physical Therapy and its staff to discuss my health and/or billing information as it relates to my physical therapy treatment with the following individuals or entities:

Name: _____ Relationship to patient: _____

This information may be shared until (date): _____

Name: _____ Relationship to patient: _____

This information may be shared until (date): _____

Name: _____ Relationship to patient: _____

This information may be shared until (date): _____

I understand that if I wish for this information to no longer be available to the above-mentioned person or people before said expiration date, I must revoke this permission in writing.

Signature: _____ Date: _____

Printed name: _____