Physical Therapy Intake
Vertigo / Dizziness / Imbalance

Name:_____

Date of Birth: _____ Age: _____

Sex: F / M Height: _____ Weight: _____

Occupation:_____

History of Present Illness

a. Why are you seeking care from a Physical Therapist?

b. When did your problem first start (date)?	Was it associated with a related event (i.e., head injury, illness, flu)?

c. Have you been treated for this problem before? Please explain.	If yes, when and where?

d. In the last 30 days, have you received services from a hospital, nursing home, or home health agency?
If yes, when? Who?

e. Check any of the following symptoms you experience:

	Blurred Vision		Nausea / Vomiting		Irregular Heart Beat
	Double Vision		Sensation of Rocking On A Boat		Lightheadedness
	Loss of Vision		Vertigo: Environment Spinning		Trouble Concentrating
	Trouble Hearing		Headaches		Trouble Scanning Environment
	Ringing in Ears		Unsteadiness		Loss of Balance

f. Was the onset of your symptoms (check one):

	Sudden		Gradual		Overnight		Other:

g. Are your symptoms (check one):		Constant		Variable (comes and goes in spells)

If variable:

I. Spells occur every _____ Hour _____ Day _____ Week _____ Month _____ Year
II. Spells usually last _____ Seconds _____ Minutes _____ Hours _____ Days
III. Are you free of symptoms between spells? _____ Yes _____ No

h. Do your symptoms occur when changing positions?		Yes		No

If yes, check all that apply:				
	Rolling Left / Right in Bed		Turning Head Side to Side	
	Moving from Sitting to Standing		Looking Up with Your Head	
	Moving from Lying to Sitting		Bending Forward with Head Down	

i. Is there anything that makes your symptoms worse?		Yes		No

If yes, check all that apply:				
	Moving Head Rapidly		Large Crowds	
	Loud Sounds		Coughing or Straining	
	Physical Activity		Scanning Aisles at Grocery Store	

j. What alleviates your symptoms?	

k. Have you fallen as a result of your current problem?		Yes		No

If yes, please explain last fall:	

Patient Name: _____

Medical History

a. Please list all medications you are currently taking (Required):

Medication Name	Frequency	Dosage	Route of Administration

b. Please mark all that apply to you currently or in the past:

	High blood pressure		Hernia		HIV
	Sensitive to ice/heat		Seizures		Vision problems
	Heart attack		Balance Issues/Dizzy spells		Diabetes
	Heart disease		Smoker		Headaches
	Kidney problems		Metal implants		Hearing problems
	Nervous disorder		Pacemaker		Arthritis
	Asthma		Ulcers/ stomach problems		Cancer

c. Please list any allergies you have:

e. Is there anything else you would like your Physical Therapist to be aware of?

The above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____

Physical Therapist Printed Name: _____

Patient Name: _____

Patient Information Consent: HIPAA Release

I have read and fully understand Rehab United's Notice of Information Practices. I understand that Rehab United may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Rehab United will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Rehab United's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Responsibilities

1. **Check in/Sign-in for each visit:** Please check in with the front office at every visit. You will need to sign in with the appropriate date and time.

2. **Payment is due at the time of service:** Deductibles, co-insurances, co-payments & wellness payments are due at the time of your appointment. RU urges you to place a credit card on file for automatic payments at the time of your appointment.

3. **Update your information with the front office:** Please inform the front office of any changes to your insurance and/or personal information. This is imperative to ensure all claims are processed correctly and in a timely manner.

4. **Scheduling appointments:** Appointment availability is on a first-come, first-served basis. Please work with the front office to schedule your future appointments as far in advance as possible to ensure you secure your preferred times. *Please note that the front office does not schedule visits without the patient or guardian requesting an appointment slot. Appointments are not reserved for "normal" schedules.

5. **Personal belongings:** RU provides small storage space (with no locking feature) for your car keys and smaller items, but does not have the space for other personal belongings. You assume the liability for the safety of your personal items.

6. **Check out with the front office staff after each visit:** Please check out with the front office after every visit. The front office will confirm your next appointment and assist in scheduling future appointments at this time.

Cancellation & No-Show Policy

We are dedicated in assisting you in meeting your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program, which will result in quicker recovery and better outcomes.

To cancel or re-schedule your appointment, **we require that you notify us at least 24 hours in advance.** Appointments are in high demand, which is why Rehab United follows a strict cancelation policy, and your early cancellation will allow the time to be reallocated to another patient who will benefit from the treatment.

When a patient is late the entire schedule is affected. Therefore, we politely ask that our patients be prompt in being present at the time of their scheduled appointments. We reserve the right to reappoint patients arriving 15 minutes after their scheduled appointment time.

****Late Cancellations:** A cancellation is considered to be late when the appointment is cancelled without a 24-hour advance notice. A **Cancellation fee of $50.00** will be charged to the patient.

- Cancellation Fee may be waived if the canceled appointment is rescheduled and attended within the same week.
    - If the Late Cancellation is scheduled for a Friday, there is no option to reschedule and have the fee waived.

****No Show Policy:** A "no-show", is a patient who misses or doesn't show for an appointment without cancelling it. A **No-Show Fee of $60.00** will be charged to the patient. **These fees are not covered by your insurance.**

Patient Name: _____

Helpful Hints to Avoid CX & No-Show Fees:

- Ask the front office to activate either an email or text appointment reminder notification.
- Check out with the front desk after every visit to confirm your next appointment.
- Request a printout of your scheduled visits from the front desk and retain this for your reference. This print out is what Rehab United has in their schedule and is the system to which we follow for all appointment times.
- If you need to cancel, call Rehab United and speak to a front office representative or leave a message if after hours.
- The front office is responsible for all therapists' schedules, so always inform the front office of cancellations or needs to re-schedule. **Telling/calling a therapist and/or aide is not acceptable notice.

I have read and understand the above policies. By signing below, the patient and/or guardian hereby acknowledge and certify that he/she has read and understand the information outlined above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Remote Therapeutic Monitoring (RTM)

RTM was developed to help improve patient outcomes & goals by supporting patient adherence to home exercise programs and patient care outside of the clinic. Patients can expect to see the following benefits from enrolling in RTM:

- Increased access to their therapists through secure messaging.
- Early intervention based on how the patient is doing with their care program.
- Tools that allow the patient to track their progress; see tangible improvements motivating continued accountability which may result in being able to taper down the frequency of in-person visits during later stages of recovery, saving the patient money.
- Improved patient functional outcomes and pain levels.

RTM Enrollment Consent:
I give consent to enroll in "Remote Therapeutic Monitoring" administered by Rehab United. I understand that services rendered to me by Rehab United Sports Medicine & Physical Therapy are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance to pay my benefits directly to Rehab United and I understand that I will be fully responsible for any outstanding balance on my account. Any outstanding balance will be collected after the service is rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Photo and Video Release (Optional)

I hereby authorize Rehab United Sports Medicine and Physical Therapy and Fit Societe to use my testimonial, photos, videos, audio and any information contained herein in its media, public relations, marketing, social media, and educational efforts. I understand and approve the disclosure of the testimonial, photo, video, or audio information to the media and other individuals and entities that may be involved in these efforts for Rehab United Sports Medicine and Physical Therapy and Fit Societe.

I authorize Rehab United Sports Medicine and Physical Therapy and Fit Societe to disclose limited information about my condition or treatment for these purposes, and understand that no other protected information will be disclosed publicly, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Rehab United Sports Medicine and Physical Therapy and Fit Societe from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio or information in the testimonial. By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described.

Patient or Parent/Guardian Signature: _____ Date: _____

Patient Name: _____

Credit Card Authorization (Optional)

Deductibles, Copays, and Co-Insurances are due IN FULL at the time of service. At the beginning of treatment, we request you secure your account with a credit card. This card will only be charged with your permission (indicated by your selection below). We offer two options for charging the patient responsibility relating to your treatment. As a courtesy to you, we can automatically charge your card the estimated patient responsibility for each visit based on the quoted benefits from your insurance company throughout your treatment. Once your claims have been processed, the Explanation of Benefits from your insurance company will determine the patient responsibility and any necessary changes to the amount due will be made. Additionally, we will use the credit card to process any cancellation or no-show fees that you have incurred (FSA/HSA Cards will not be charged cancellation and/or no-show fees). A receipt will be provided for any charges processed by Rehab United, at your request. If you prefer to bring in payment at every appointment, we will use your credit card on a monthly basis to charge any remaining fees owed once claims have processed by your insurance company and/or any missed payments for services already provided.

Credit Card Information			
☐ Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ FSA ☐ HSA			
Name on Card:			
Card Number:			
Expiration Date:		Security Code:	
Billing Address:			
Amount to Be Charged:		Do You Require an Itemized Receipt?	☐ Yes ☐ No

Please Initial the Option You Prefer	
	CHARGE AT TIME OF SERVICE: I agree to allow Rehab United to charge my credit card on file for the amount due at each appointment and for any remaining balance I owe.
	CHARGE BALANCE OWED: I will pay the estimated amount due per session at each appointment and will have my credit card on file available **only** for any remaining balance I owe.

☐ I require notification for any charge larger than $_____ ☐ I don't require notification.

I have read this Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Rehab United Sports Medicine and Physical Therapy, Inc. Furthermore, I agree to assign all health insurance benefits directly to Rehab United Sports Medicine and Physical Therapy, Inc. and understand that I am responsible for any costs not covered by my health insurance.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____