Out of the Box Physical Therapy, LLC

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

NAME: ____

ADDRESS:______________________________________CITY______________________STATE______ZIP_________

DATE OF BIRTH: ____________________ AGE:_______________ GENDER: ▢ MALE ▢ FEMALE ▢ OTHER_________________

CONTACT INFORMATION: ▢ HOME_____________ ▢ CELL________________ ▢EMAIL______________________________

EMERGENCY CONTACT: NAME/RELATIONSHIP: ____ #: ____________________

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OTB? ____

REFERRING PHYSICIAN: ____

PHONE #: ________________________________ FAX #: ________________________________

PRIMARY PHYSICIAN: ____

PHONE #: ________________________________ FAX #: ________________________________

Have you received physical therapy within the last 12 months? ▢ Yes ▢ No

Have you received other services for your current issue? ▢ Yes ▢ No If yes, please explain:

Is this injury: ▢ Work Related ▢ An Injury ▢ Neither

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ____

MEMBER ID #: _______________________________

POLICY HOLDER: ▢ Patient ▢ Other Name: ______________________ DOB: __________ Relationship: ___________________

SECONDARY INSURANCE COMPANY: ____

MEMBER ID #: _______________________________

POLICY HOLDER: ▢ Patient ▢ Other Name: ______________________ DOB: __________ Relationship: ___________________

MEDICAL HISTORY

CURRENT CONDITION:
Please describe your current symptoms

____

____

____

HEIGHT: _______________ WEIGHT: ________________

Do you smoke? ▢ Yes ▢ No Do you drink alcohol? ▢ Yes ▢ No Drinks/week________

MEDICATIONS:
Please list all over the counter and prescription medications you are currently taking. Include dosage & frequency.

____

____

____

SURGICAL HISTORY:
List any surgical procedures you have had and the dates they were performed.

____

____

____

DIAGNOSTIC TESTING:
Please check any diagnostic testing and/or treatments you have completed for this condition.

▢ MRI ▢ Nerve Block ▢ X Ray ▢Blood Tests ▢EMG ▢ Injections ▢Other:

▢CT Scan ▢Ultrasound ▢Bone Scan ▢Doppler Studies ▢Cardiac Stress Test ▢Urinalysis

MEDICAL CONDITIONS
Please select all that apply:

▢ Congenital Heart Defect
▢ Heart Problems/Heart Disease
▢ Joint, Tendon or Muscular Pain Gastrointestinal Issues
▢ Skin Problems
▢ Psychological
▢ High or Low Blood Sugar
▢ High Cholesterol
▢ Emphysema
▢ Poor Balance Recent Falls
▢ Dizziness/Vertigo/Fainting/Blackouts
▢ Severe Headaches
▢ Prostate Problems
▢ Epilepsy/Seizure Disorders
▢ Circulation Problems/ Blood Clots
▢ Liver Disease
▢ Sexually Transmitted Disease/HIV/AIDS Tuberculosis
▢ Thyroid Problems
▢ Diabetes
▢ Chemical Dependency (Alcoholism)
▢ Lyme Disease
▢ Depression/Anxiety/Panic Attacks
▢ Other:

▢ Cancer
▢ Joint Replacement/Repair
▢ Osteoporosis
▢ Pacemaker
▢ High or Low Blood Pressure
▢ Chest Pain/Angina/Palpitations
▢ Abdominal Pain/Bloating/Gas
▢ Shortness of Breath
▢ Coughing/Wheezing or Exertion
▢ Gout
▢ Rheumatoid Arthritis
▢ Anemia
▢ Ulcers
▢ Depression
▢ Kidney Disease
▢ Lung Disease
▢ Allergies Asthma/Bronchitis/Pneumonia/Chronic Cough
▢ Stroke
▢ Latex Allergy
▢ Hepatitis A, B, C
▢ Painful Bowels/Loose Stool/Constipation Multiple Sclerosis

Please provide details regarding the above checked conditions:

____

____

____

In the past 3 months have you experienced any of the following?
Select all that apply:

- ▢ Pregnancy
- ▢ Nausea/vomiting
- ▢ Dizzy/lightheaded
- ▢ Fatigue
- ▢ Bowel/bladder changes
- ▢ Numbness or tingling
- ▢ Sudden weight loss/gain
- ▢ Shortness of breath
- ▢ Fever/chills/sweats

If yes to any of the above, please explain:

____

By signing below, I confirm that I have completed the above truthfully to the best of my knowledge..

____

PATIENT NAME (print)

____

PATIENT/GUARDIAN/POA SIGNATURE **Date**

POLICIES AND AUTHORIZATIONS

Please initial next to each section to confirm that you've read, understand and agree to all of the statements below. Authorization can be revoked in writing at any time. Out of the Box Physical Therapy, LLC will hereafter be referred to as "OTB".

AUTHORIZATION FOR RELEASE OF INFORMATION

_______ I agree that OTB may provide information from any part of my medical records via phone, email, fax or mail to those involved in my medical care.

_______ I agree that OTB can discuss my medical information with other members of my care team (e.g. PCP, orthopedist, personal trainer/coach, massage therapist, etc.).

CONSENT TO RELEASE OF INFORMATION TO VOICEMAIL AND EMAIL

_______ I agree that voicemail messages can be left on the phone number provided regarding appointments and billing inquiries.

_______ I agree to being contacted by email to receive billing inquiries and other notices regarding my care.

FINANCIAL AUTHORIZATION

_______ I understand that payment for treatment must be provided up front at the beginning of the treatment session.

_______ I agree to provide my payment in full at the beginning of each treatment session.

MEDIA CONSENT RELEASE

I grant OTB permission to record my likeness and voice by video, audio, photographic or any other medium. OTB may use these "recordings" and may use, reproduce, exhibit or distribute them in any medium (e.g. print, video, online, social media) for promotional or educational purposes without providing compensation.

▢ I grant permission ▢ i ***do not*** grant permission

I confirm that I have read, fully understand and agree to all of the statements above.

PATIENT NAME (print)

PATIENT/GUARDIAN/POA SIGNATURE **Date**

AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

I consent to have Out of the Box Physical Therapy, LLC (hereafter referred to as “OTB”) and/or its affiliated provide the treatment and care deemed necessary by my DPT (Doctor of Physical Therapy) and as permitted by NJ Statutes under the appropriate scope of practice. I , the undersigned, acknowledge the inherent risks involved in physical therapy and the use of fitness equipment. Accordingly, as consideration in exchange for being allowed to participate in any activities at OTB, I hereby agree to the following:

1. I acknowledge that I am participating in a physical therapy/exercise program offered by OTB during which I will receive treatment, instruction and information about health and fitness. I acknowledge that no guarantees or assurances have been made concerning the results of my treatment. I recognize that physical therapy/exercise programs require physical exertion, which may be strenuous and may cause physical injury, permanent disability and even death, and I am fully aware of the risks and hazards involved.
2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the physical therapy/exercise program. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in the physical therapy/exercise program.
3. In consideration of being permitted to participate in the physical therapy/exercise program or any other ancillary services. I agree to assume full responsibility for any risks, injuries, permanent disability, death, or damages, known or unknown, which I might incur as a result of participating in the program. If, however, I observe an unusual significant hazard during my participation, I will remove myself from participation and bring such hazard to the attention of the management.
4. In further consideration of being permitted to participate in the physical therapy/exercise program, I knowingly, voluntary, and expressly waive any claim I may have against OTB, its members, managers, affiliates, officers, directors, employees, agents or any therapies (collectively “Releasees”), for injury or damages that I may sustain as a result of participating in the program. I also agree to indemnify Releasees from any and all third-party claims caused or resulting in whole or in part by my actions. I, my heirs and legal representatives forever release, waive, discharge and covenant not to sue any of the Releasees, for injury or death caused by their negligence or other acts.
5. I consent to emergency medical care and transportation in order to obtain treatment in the event of injury to me as OTB may deem appropriate. The releases contained herein extend to any liability arising out of or in any way connected with the medical treatment and transportation provided in the event of any emergency
6. I expressly agree that the terms of release and indemnity contained herein are intended to be as broad and inclusive as is permitted by the laws of the State of New Jersey. Any provision or portion of this Agreement of Release and Waiver of Liability found to be invalid by the courts having jurisdiction shall be invalid only with respect to such provision or portion hereof. The offending provision or portion shall be construed to the maximum extent possible to confer upon the parties the benefits intended thereby. Said provision or portion hereof, as well as the remaining provisions or portion hereof, shall be construed and enforced to the same effect as if such offending provision or portion thereof had not be contained herein.

PATIENT NAME (print)

PATIENT/GUARDIAN/POA SIGNATURE **Date**

IF PARTICIPANT IS UNDER THE AGE OF 18:
As parent of legal guardian of _______________________________________, I consent to the above terms and conditions. I understand that by signing this agreement I am giving up substantial rights on behalf of my child and myself.

PARENT/GUARDIAN/POA NAME (print)

PARENT/GUARDIAN/POA SIGNATURE **Date**