All Care Therapies
OF GEORGETOWN

Occupational Therapy•Physical Therapy•Speech Therapy

Patient Information

First Name:_____________________ Last Name:_______________________

Gender:_________________________ Date of Birth:____________________

Address:___________________________________ Apt./PO Box:__________

City:_____________________________ State:______________ Zip:________

E-mail address:____

☐ I would like to receive updates and news letter from All Care Therapies to my e-mail address.

How did you hear about us? Please circle one:

Internet Search Doctor Insurance Friend. Who?:_________________

Other:____

Phone Numbers

Home Phone:____________________ Work Phone:_____________________

Cell Phone:_____________________ Cell Phone Provider:________________

Preferred Method of Appointment Reminder (circle one): Text Email

Emergency Contact

First Name:_______________________ Last Name:_____________________

Phone Number:____________________ Relationship:___________________

Is this person authorized to take the patient from the clinic?

Circle one: YES NO

Employer

Company Name:____

Address:________________________________ Suite/Office #:_________

City:___________________________ State:_____________ Zip:_______

Physician

Primary Care Physician (full name if known):__________________________

Clinic:____

Clinic Address (if known):_____________________________

Clinic Phone (if known):______________________________

Problem

Problem Description:____

Date of Onset:____

Pain Level at Rest (circle one): 1 2 3 4 5 6 7 8 9 10

Pain Level With Use (circle one): 1 2 3 4 5 6 7 8 9 10

Medical Information

Current Medications:____

Known Allergies:____

Surgery

Type of Surgery:____

Date of Surgery:____

Current Restrictions (if any): ____

Primary Insurance

Insurance:____________________________ ID Number:_________________

Group Number:_______________________ Claim Number:______________

Deductible:_____________________ Max Annual Benefit:________________

Copay:_____________________ Coinsurance:_________________________

Subscriber Information

Subscriber Full Name:____

Subscriber DOB:____

Subscriber Relation to Patient:_______________________________________

Secondary Insurance

Insurance:____________________________ ID Number:_________________

Group Number:_______________________ Claim Number:______________

Deductible:_____________________ Max Annual Benefit:________________

Copay:_____________________ Coinsurance:_________________________

Subscriber Information

Subscriber Full Name:____

Subscriber DOB:____

Subscriber Relation to Patient:_______________________________________

Tertiary Insurance

Insurance:____________________________ ID Number:_________________

Group Number:_______________________ Claim Number:______________

Deductible:_____________________ Max Annual Benefit:________________

Copay:____________________ Coinsurance:________________________

Subscriber Information

Subscriber Full Name:____

Subscriber DOB:____

Subscriber Relation to Patient:_____________________________________

Motor Vehicle Accident Injuries

If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in? ____

Patient or Guardian Agreement:

- I authorize release of information requested by my insurance plan for payment.
- I understand that I am responsible for any balance due not covered by my insurance, including co-pays, coinsurances, and deductibles
- I understand that any co-pays required by my insurance company are due at the start of my treatment session.
- I agree to comply with the terms and conditions as outlined in the Patient Registration form.
- I understand that I must notify All Care of any changes in insurance and/or primary care provider immediately.

Signature of Patient/Guardian:_____________________________________

Date:____

Emergency Medical Treatment Release

I, __________________, do hereby give my consent to the Directors of All Care Therapies of Georgetown to administer medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of emergency in the event my consent can not be obtained.

Signature:____

Date:____

Notice of Privacy Practices, Privacy Sheet, Patient Rights and Responsibilities, Attendance Policy, and Clinic Rules

(Laminated Pages if in clinic or attached if via email)

I have read the laminated document provided with this patient intake packet and understand it. I understand that I have the right to ask for a non-laminated copy of the document (or sections of the document) to take home, or have a copy emailed to me. I know that I can also find this document on the clinic website, www.allcaretherapygt.com.

I have read, understand, and agree to the Notice of Privacy Practices, Privacy Sheet For Client, Patient Rights and Responsibilities, Attendance Policy, and the Clinic Rules. I consent to the use and disclosure of my healthcare information for purposes of treatment, payment, and healthcare options.

____

Signature Date

If you are signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

____

Signature Date

Source of Authority/Relationship:_____________________________________

Photo/Video Release

All Care Therapies of Georgetown occasionally takes photos or short videos for treatment and assessment purposes. All Care also has a website (www.allcaretherapygt.com) that is used for promotion and education.

Below is permission or a decline for All Care Therapies of Georgetown to use these photos/videos for educational purposes and legal promotion of the clinic.

Check ONLY ONE Box Below and Fill Out ONLY ONE Section Below

Permission to use Photograph

I grant All Care Therapies of Georgetown, its representatives, and employees to take photographs/video of the patient. I agree that All Care may use such photographs of the patient with or without their name and for any lawful purpose, including, for example, such purposes as education, publicity, illustration, advertising, and Web content.

☐ I have read and understand the above and give permission for the above use

Patient Name:____

Signature of Patient/Legal Guardian:________________________________

Printed Name:____

Date:____

☐ **Check here if you DO NOT want picture or video taken and used for publicity, but grant permission to use photos or videos for treatment or assessment purposes.**

Patient Name:____

Signature of Patient/Legal Guardian:________________________________

Printed Name:____

Date:____

--------- --------- --------- --------- --------- --------- --------- ---------
--------- --------- --------- --------- --------- --------- --------- ---------

☐ **Check here if you DO NOT want the pictures or video taken of the patient for any purpose.**

Patient Name:____

Signature of Patient/Legal Guardian:________________________________

Printed Name:____

Date:____

Evaluation Explanation

Thank you for the opportunity to perform your evaluation. It is All Care's goal and mission to serve the individuals in our area, to help them be more independent, and to improve their quality of life.

After the evaluation is performed, your therapist will score it to determine if therapy intervention is recommended. If therapy is recommended, we will send a request for treatment to the physician to obtain a prescription for treatment. We cannot begin therapy treatment without this prescription. It may take several weeks for your physician to return the prescription for treatment and your insurance provider to authorize therapy treatment. We encourage you to follow up with your physician and insurance provider to ensure communication between parties and timely initiation of therapy treatment. As soon as we receive the prescription for treatment and authorization, we will contact you to begin your therapy treatment. Therapy treatment often is recommended 2 to 3 times per week for 30 to 60 minutes each session. The exact amount will be suggested by the therapist. Please be sure that you can commit to this amount of time for your therapy. As explained in our attendance policy, consistent attendance and participation in therapy is vital to patient progress.

It may be possible for your therapist to score the evaluation the same day the evaluation is given to determine if there is a need for therapy intervention. If the evaluation is scored the same day, the therapist may discuss the results with you if there is time. If therapy is recommended, the therapist may even discuss possible treatment days and times with you. If you have any questions or concerns about the evaluation or treatment scheduling, please do not hesitate to bring them to the attention of your therapist.

If the evaluation cannot be scored the same day, we will contact you about the results and recommendations of the evaluation as soon as the evaluation is scored. A written evaluation report will be completed and a copy will be provided to you for your records.

If at any time you have any questions about how this process works or a concern about therapy, please ask. It is our goal to meet and exceed your expectations for therapy.

Thank you for choosing us,

All Care Therapies of Georgetown