Jerry Valentine, PT. ● Miriah Humphreys, PTA.

Phone: 817.502.741 ● Fax: 817.502.7412

www.brainandback.com

# New Patient Intake Forms

## Patient Information

Last Name: ________________________________ First Name: __________________________ Initial: _____
Address: _____________________________ Apt# _____ City: _________________ State: ____ Zip: _______
Home Phone: (____) _____ - _______ Cell Phone: (____) _____ - _______ Work Phone: (____) _____-______
Date of Birth: ____/____/____ Gender: □ M □ F SSN # ____-____-____
Marital Status: □ Single □ Married □ Divorced □ Widowed
Parent/ Legal Guardian if Patient is a Minor: ____________________________________________________

**Primary Doctor** ________________________________ Phone Number/ City ___________________________
**Referring Doctor** ______________________________ Phone Number/City____________________________
□ Insurance Carrier □ Friend/Family □ Internet □ VA □ Other_____________ □ Hospital: _____________

Employers Name: __________________________________ Occupation: ______________________________
Employers Number: (_____) _____ - _______ Are you a Veteran of the US Armed Forces? □ YES □ NO

## Emergency Contact

Name: _________________________________Relationship: ______________________
Home #: (_____) _____ - _______ Cell #: (_____) _____ - _______ Alternate #: (_____) _____ - _______

## Insurance Information

Policy Holder: _________________________________ SSN # _____-_____-______ D.O.B ____/____/_____
Primary Insurance Company: ____________________Policy #________________Group # ________________
Second Insurance Company: _____________________ Policy # ________________ Group #________________

**Email Address**: __________________________________________________
Race: □ Asian □ White □ American Indian/Alaska Native □ Hispanic □ African American □ Other: __________
Language: □ English □ Spanish □ Other: ________________

Jerry Valentine, PT. ● Miriah Humphreys, PTA.

Phone: 817.502.741 ● Fax: 817.502.7412

www.brainandback.com

# Office Policies

**CONSENT FOR TREATMENT FORM**

__________ I understand that I have presented myself to AXBBI Therapy for evaluation and/or treatment for my condition. I authorize and direct AXBBI Therapy to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments.**I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature**. I grant this consent without duress, confusion, or pressure from my physician and/or his/her associates, or colleagues.

**Treatment of Minors**

__________ I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. (Please enter NA if you are not a minor)

**ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT**

__________ I hereby give authorization of insurance benefits to be made directly to AXBBI Therapy services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. If I have multiple primary insurance policies, I acknowledge I am responsible for coordinating primary vs. secondary with my insurance companies. Failure to do so will result in claim denials and refusal to pay. I further agree that a photocopy of this agreement shall be as valid as the original.

__________ I understand payment is due at time of service. Payment can be made by cash, check Visa, MasterCard, Discover or Amex. There is a $1500 limit for credit card transactions.

__________ I understand that I am financially responsible for all charges at time of service including copays, deductibles and coinsurances. In the event of denials, errors, service caps, policy exclusions or non-covered services, I am responsible for payment of all services rendered. I understand that any account balance incurred must be paid in full prior to scheduling surgery.

__________ I understand AXBBI, PPLC reserves the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery. In the event of default, I agree to pay all costs of collections which constitutes balance due plus a 35% collection fee.

**SHARING OF INFORMATION FOR PURPOSE OF PAYMENT**

__________ I acknowledge that AXBBI Therapy will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including,

Jerry Valentine, PT. ● Miriah Humphreys, PTA.

Phone: 817.502.741 ● Fax: 817.502.7412

www.brainandback.com


but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

**COMMUNICATION AUTHORIZATION**

_________ I acknowledge that AXBBI Therapy may communicate with me via US mail, Home/Cell Phone (____) _____ - _______) and through the patient portal for both medical and financial purposes.

**ACKNOWLEDGEMENT OF PATIENT RIGHTS**

_________ I, have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. But any disclosures given in reliance on this prior consent will be permissible.

**ACKNOWLEDGMENT OF PATIENT RESPONSIBILITIES**

_________ I have read the **NOTICE OF PATIENT RESPONSIBILITIES** and have had any questions answered by this office. understand that by signing this form I acknowledge that I have read the **Patient Responsibilities Notice posted in all AXBBI Therapy locations.** My consent is freely given. I understand that I may revoke this consent at any time, if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

_________ I acknowledge that AXBBI Therapy has provided me with the opportunity to view and read a written copy of **NOTICE OF PRIVACY PRACTICE.**

**DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION**

_________ I acknowledge that AXBBI Therapy will disclose my protected Health Information (PHI) to a family member, other relative, close friend or any other person I identify that directly relates to that person's involvement in my care. The following are authorized person(s) who my PHI may be disclosed to:

**Name(s)**:_______________________________________________

**Name(s)**:_______________________________________________

**Name(s)**:_______________________________________________

__________ **I OBJECT** to the disclosure of my Protected Health Information to a family member, other relative, close friend or any other person.

_____________________________________ _________________________

Patient or Legal Guardian Signature Date

_____________________________________

Patient Printed Name

Jerry Valentine, PT. ● Miriah Humphreys, PTA.

Phone: 817.502.741 ● Fax: 817.502.7412

www.brainandback.com

## Axis Brain and Back Physical Therapy No Show / Cancellation Policy

Please read carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable; however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Missed appointments are a significant inconvenience to your physical therapy, the clinic and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. After missing two appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.
3. A No Show Fee of $75.00 may be assessed if you do not show up for a scheduled appointment without a call or email prior to your appointment. If you have 3 No Shows in a plan of care then you will be discharged from Physical Therapy and you will have to return to see your doctor to get a new PT prescription.
4. Certain accident claims, worker's compensation and VA adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly possible. Missing appointments hinders that process and may end up prolonging recovery.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy. Our phone number is 817-502-7411 and our email is PTinfo@axbbi.com.

______________________________________ __________________________

Patient or Legal Guardian Signature Date

______________________________________

Patient Printed Name

Axis Brain & Back Institute, PLLC

Jerry Valentine, PT. ● Miriah Humphreys, PTA.

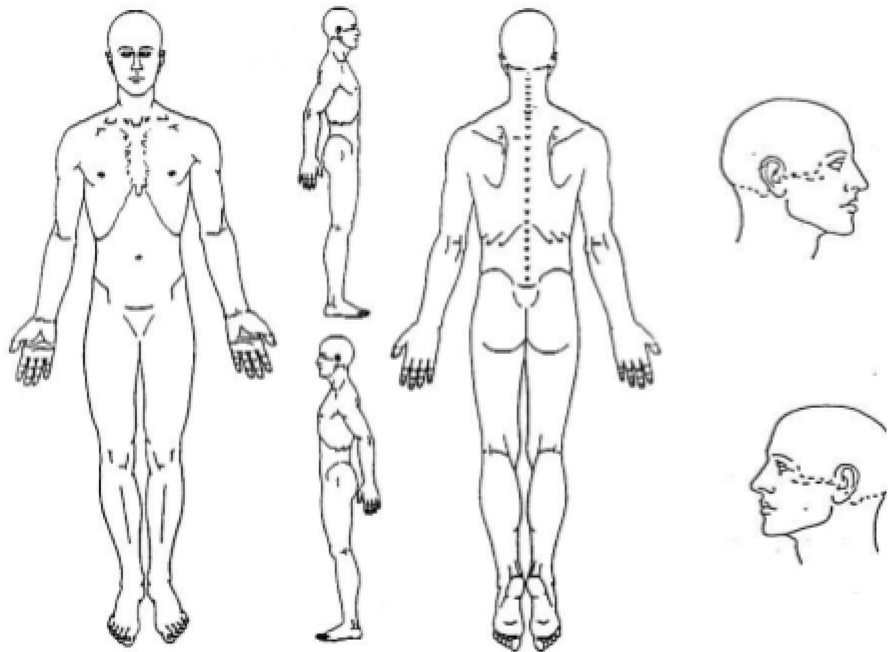
Phone: 817.502.741 ● Fax: 817.502.7412

www.brainandback.com

Please mark the area of discomfort by using the appropriate letter(s).

X = Pain B = Burning

T = Tingling W = Weakness



On a PAIN SCALE of 1- 10 what number would you consider yourself?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10