YOUNGS
PHYSICAL THERAPY &
SPORTS PERFORMANCE

PATIENT INFORMATION

Mr. **Mrs.** **Ms.**	**First Name**	**Last Name**	**Middle Initial**	**Preferred Name**	**Social Security Number**

Gender Male Female	**Date of Birth** MM/DD/YYYY	**Marital Status** Married Single Divorced Separated Widow	**Employment** Employed Unemployed Retired	**Student** Full-Time Part-Time None	**Email Address** May we send you appointment reminders via email? YES/NO

Home Phone Number May we leave messages on your answering machine? YES/NO	**Cell Phone Number** May we send you appointment reminders via text? YES/NO	**Alternate Phone Number**

Mailing Address	**Apartment #**	**City**	**State**	**Zip Code**

Why is the patient being seen today? **Right** **Left** **Both**	**Sports Related Injury?** YES NO	**Post Operative?** YES NO Date:	**Preference of Therapist?**	**Worker Compensation?** YES NO Injury Date:	**Result of an Auto Accident?** YES NO Date:

Referring Doctor or SELF:	**Dr. Office:**
Person Making Appt if other than pt:	**Appt Day and Time:**

EMERGENCY CONTACT

Relationship to Patient	**First Name**	**Last Name**	**Middle Initial**	**Phone Number**	This person has permission to discuss medical records for the patient? YES or NO

Address (If different from above)	**Apartment #**	**City**	**State**	**Zip Code**

INSURANCE INFORMATION

PRIMARY Insurance Company Name	**Subscriber Id/Member Number**	**Group Number**

Name of Policy Holder (If different than patient) First Name Middle Initial Last Name	**Relationship to Insured:**	**Policy Holders Date of Birth** MM/DD/YYYYY	**Gender** Male Female	**Policy Holders SS Number**

Policy Holder's Mailing Address (If different from above)	**Apartment**	**City**	**State**	**Zip Code**

SECONDARY Insurance Company Name ***INITIAL HERE*** **if NO Secondary Insurance Coverage ____**	**Member Number**	**Group Number**

Name of Policy Holder (If different than patient) First Name Middle Initial Last Name	**Relationship to Insured:**	**Policy Holders Date of Birth** MM/DD/YYYYY	**Gender** Male Female	**Policy Holders SS Number**

Date Verified:	Verified By:	Spoke with:	Reference #:

Effective Date: | Benefit Start Period: | End Date:

Deductible: Met: | Co-Insurance:

CoPay: | Out of Pocket: Met: | Visit Limit:

Pre Authorization Required? YES NO | Dr Prescription Required? YES NO | Notes:

Verification of benefits is not a guarantee of payment. All benefits are subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of the patient's health benefit plan at the time the services are rendered. **Signature:**

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Please **read** and **initial** indicating that you are aware of and will adhere to following policies:

_____ **The information on the Patient Intake Form is correct**. I will notify Youngs Physical Therapy & Sports Performance, Inc. immediately of any insurance changes. Failure of which may result in denial of coverage, the fees for which I will be responsible for.

_____ **Copays are due upon arrival.** All copays will be taken at the beginning of each visit.

_____ **Arriving Late:** Late arrivals may be rescheduled so that other patients may be seen on time.

_____ **Cancellations and Rescheduling:** We require a minimum of 24-hour advanced notice to cancel or reschedule appointments. A $25.00 fee may be assessed for less than 24-hour notice. This fee will not be covered by insurance.

_____ **Not showing for an appointment:** If you fail to show for an appointment without prior notice or if you cancel within 2 hours of your scheduled appointment time you will be charged a $50.00 fee and all future appointments may be cancelled.

_____ **Appointment Reminders:** We send appointment reminders via text and/or email. Please let us know if these reminders are helpful. We can adjust how you are notified to best fit your needs.

_____ **Insurance/Benefit Information:** Every attempt is made to obtain accurate physical therapy benefit information. At times, insurance companies give us incorrect information. This error will not be determined until claims are processed after services are rendered. If patients overpay for services, a refund will be issued once the patient has been discharged. If there is a balance not paid by the insurance company, the patient will be responsible for these charges. Patients are ***encouraged*** to verify their own benefits. It is ultimately the patient's responsibility to know and understand their benefits. It is ultimately the patient's responsibility to notify our office of any change in insurance. Visits can be denied due to a change in insurance, at that time patient will be responsible for any additional finances.

_____ **Social Media**: We love to highlight our patient's strengths and accomplishments by promoting their success on social media. I authorize Youngs Physical Therapy and Sports Performance to use my name, pictures, videos on their website and social media and to tag me in such posts and content.

Please **read** the statement below and **sign** indicating understanding.

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage.

I hereby give authorization for payment of insurance benefits to be made directly to Youngs Physical Therapy & Sports Performance, Inc. for services rendered. In the event that my insurance company forwards payment directly to me, instead of Youngs Physical Therapy & Sports Performance, Inc., I will immediately deliver said payment to Youngs Physical Therapy & Sports Performance, Inc.

I understand and agree that I am responsible for payment of all charges assessed for professional services rendered and will pay any sum due when requested. I understand and agree that if necessary to commence legal actions for the collection of any outstanding charges on my account, I will be responsible for any costs and/or court fees, in the addition to the outstanding balance.
Assignment of Benefits/Proceeds: I hereby instruct and direct ALL payers responsible for making payments towards the treatment of my injuries to pay Youngs Physical Therapy & Sports Performance, Inc., 1301 E Arlington Blvd., Greenville NC, 27858 for the professional or medical benefits/proceeds allowable, and otherwise payable to me as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits/proceeds under ANY applicable policies/agreements. I further intend for this Assignment to create a secured interest under the applicable Uniform Commercial Code.
Authorization to Release Information: I authorize the release of any medical or other information necessary to verify benefits/obtain payment or complete treatment.
Consent to Evaluation & Treatment: I do hereby consent to the evaluation and treatment by Youngs Physical Therapy & Sports Rehab, Inc. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Signed (Patient and/or parent or legal guardian) Date

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PATIENT NAME: ______________________________ **DATE OF BIRTH:** ____/____/____
OCCUPATION: ______________________________ **NEXT PHYSICIAN VISIT?** ____________

Medical History

Allergies ○ Yes ○ No
Anemia ○ Yes ○ No
Anxiety ○ Yes ○ No
Arthritis ○ Yes ○ No
Asthma ○ Yes ○ No
Autoimmune Disorder ○ Yes ○ No
Cancer ○ Yes ○ No
Cardiac Conditions ○ Yes ○ No
Cardiac Pacemaker ○ Yes ○ No
Chemical Dependency ○ Yes ○ No
Circulation Problems ○ Yes ○ No
Currently Pregnant ○ Yes ○ No
Depression ○ Yes ○ No
Diabetes ○ Yes ○ No
Dizzy Spells ○ Yes ○ No
Emphysema/Bronchitis ○ Yes ○ No
Fibromyalgia ○ Yes ○ No
Fractures ○ Yes ○ No
Gallbladder Problems ○ Yes ○ No
Headaches ○ Yes ○ No
Hearing Impairment ○ Yes ○ No
Hepatitis ○ Yes ○ No
High Cholesterol ○ Yes ○ No
High/Low Blood Pressure ○ Yes ○ No
HIV/AIDS ○ Yes ○ No
Incontinence ○ Yes ○ No
Kidney Problems ○ Yes ○ No
Metal Implants ○ Yes ○ No
MRSA ○ Yes ○ No
Multiple Sclerosis ○ Yes ○ No
Muscular Disease ○ Yes ○ No
Osteoporosis ○ Yes ○ No
Parkinsons ○ Yes ○ No
Rheumatoid Arthritis ○ Yes ○ No
Seizures ○ Yes ○ No
Smoking ○ Yes ○ No
Speech Problems ○ Yes ○ No
Strokes ○ Yes ○ No
Thyroid Disease ○ Yes ○ No
Tuberculosis ○ Yes ○ No
Vision Problems ○ Yes ○ No
Other: ______________________________

Describe any other conditions: If you answered, "Yes" to any of the above please explain and give approximate dates.

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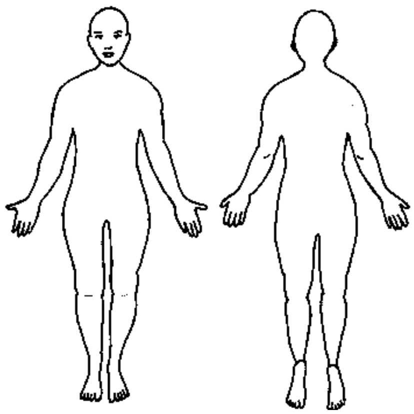

Please indicate the location of your pain in the diagram above.

Average Pain Intensity:

Pain (at rest): no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain
Pain (at worst): no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Surgical History

Body Region:_______________Surgery Type: ____________________ Date of Surgery: _______________
Body Region:_______________Surgery Type: ____________________ Date of Surgery: _______________
Body Region:_______________Surgery Type: ____________________ Date of Surgery: _______________
Body Region:_______________Surgery Type: ____________________ Date of Surgery: _______________

Current Medications and/or Supplements: Please provide a copy of your medication list if additional space is needed.

Drug:__________________Dosage:______________Frequency:_________Route:_________Reason for Taking: _______________
Drug:__________________Dosage: _______________Frequency:_________Route:_________Reason for Taking: _______________
Drug:__________________Dosage:______________Frequency:_________Route:_________Reason for Taking: _______________
Drug:__________________Dosage:______________Frequency:_________Route:_________Reason for Taking: _______________
Drug:__________________Dosage:______________Frequency:_________Route:_________Reason for Taking: _______________
Drug:__________________Dosage:______________Frequency:_________Route:_________Reason for Taking: _______________

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Patient Name:_____________________________ **Patient Date of Birth:** _____/_____/_____

Per Medicare guidelines, we must have a complete and up-to-date list of all your current medications, including dosage, frequency, route (oral, topical, injection, inhalation, transmucosal, IV) and reason for taking.

Drug: ____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

Drug:____________________ Dosage:___________Frequency:____________ Route:________ Reason for taking:_______________________________________

I verify that the above information is correct and up to date.

Patient's Signature: ___________________________________ **Date:**______________

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