TRUE NORTH
UPPER EXTREMITY & ORTHOPEDIC SPECIALISTS

Patient Intake Form

Office Use Only:

Date of Intake:	**Date Scheduled:**
Reminder Call for IE: _____ Insurance: _____	**Attire___ Paperwork___ Payment___ Late/CXL Policy___ Early___**

Name:_____ **DOB:** _____ / _____ / _____
as it appears on insurance card with middle initial

Street Address: _____

Billing Address: (if different): _____

City:_____ **State:**_____ **Zip Code:** _____

Phone #1: _____ ☐ **Home** ☐ **Cell** ☐ **Work**

Phone #2: _____ ☐ **Home** ☐ **Cell** ☐ **Work**

Email: _____

Social Security #: _____ - _____ - _____

Emergency Contact:_____ **Phone Number:** _____ **Relationship to Patient:**_____

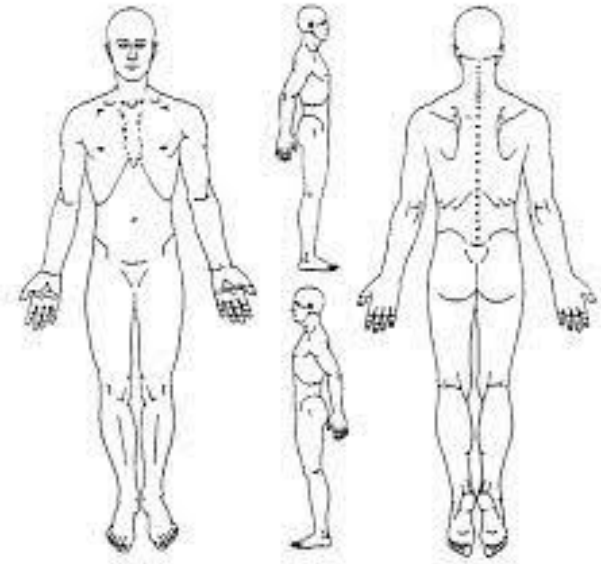
How did you hear about or find our Office?_____

For what are you seeking treatment? _____ **Date of injury/surgery:** _____

Is condition related to: ☐ work ☐ Auto Accident (State: _____) ☐ Personal Liability ☐ None

Have you received any therapy this calendar year? _____

Do you have pain with your condition? If so: Circle the area of pain and indicate level of pain below:



Pain Scale 0= none and 10= I'm going to the ER
Is your pain intermittent or constant? (circle)
Pain at present? _____
Pain at best last week? _____
Pain at its worst last week? _____

WorkStatus: Employed Part-time/Full-time WorkRestrictions (if any)_____

Retired Disabled (__Total or __Temporary) Homemaker Student:Part-time/Full-time

Occupation: _____ **Employer & Phone No:** _____

Name of Referring Physician & PhoneNumber_____

Name of Primary Care Physician & Phone Number:_____

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PAYMENT OPTIONS: *(Please **INITIAL** next to the payment option you're using)*

_____ **Private Pay** – Not using insurance; I am paying by cash, check, debit or credit card or e-check at the time of service.

Initials You have been offered the opportunity to personally pay for your therapy evaluation and treatment at TrueNorth Upper Extremity and Orthopedic Specialists, LLC. The private pay policy may be used in the following circumstances:

1. You have no insurance
2. Therapy is not covered by your insurance

The following conditions apply:

1. **Once you have chosen the private pay terms, we will NOT bill you or an insurance carrier for services rendered.**
2. **Payment is due at the time of service.** We accept cash, checks, debit and credit cards or e-checks. **There is a $30.00 service charge for returned checks.**
3. **If payment is not paid at the time of service, you will be billed a $15.00 administrative fee in addition to the treatment charge.**
4. **Initial Evaluation: $125.00. Follow-up visits for the same diagnosis: $100.00.** (Orthotics/splints, DME, or supplies are not included in these prices.)

_____ **Health Insurance or Medical Sharing or Health Share Plan***

initials Primary Insurance Company: _____ Phone #:_____
Plan ID #: _____ Group Number: _____
Policy Holder: _____ Date of Birth: ____ / ____ / _____ SS#: _____ - ___ - _____
Secondary Insurance Company: _____ Phone #: _____
Plan ID #: _____ Group Number: _____

***Medical Sharing, Health Share and Healthcare Sharing Ministry clients will be provided a 50% discount if payment is made at time of service, 40% if patent is made within 30 days of the service, 30% if payment is made within 60 days of service and 20% if payment is made within 90 days of service. Payments made after 90 days will not be discounted.**

_____ **Worker's Compensation**

initials Primary Insurance Company: _____ Phone #: _____
Claim Number: _____ Date of Injury: _____
Employer Insuring the Claim & Phone #: _____ (_____) _____ - _____
Name of Adjuster: _____ Phone #: _____
Name of Case Manager: _____ Phone #: _____

_____ **Auto Insurance/Med Pay/Liability:**

initials Auto Ins./Medpay Company: _____ Phone #: _____
OR Auto Ins./Lien Company: _____ Phone #: _____
Claim Number: _____ Name of Adjuster: _____
Adjuster Phone #: _____ Date of Injury: _____

TrueNorth Upper Extremity and Orthopedic Specialists, LLC accepts auto/liability claims under the following conditions:

1. Medical benefits on the patient's Med Pay are accepted; however, in addition, patient must have:
   a. Private health insurance that will be billed for treatment in the event that the medical on their auto/liability policy is exhausted, or
   b. Patients must pay for treatment at the time of visit with a credit card that will be kept on file for future payments.
2. If a patient is using private health insurance, they are responsible for any copay, coinsurance, and/or deductible dictated by their insurance plan.
3. Patients who have a lien with a private company are accepted; however, patients with an attorney lien only,will be considered on a case by case basis. A medical lien will be filed with the responsible party's insurance company for any balance over $1500. If a lien is filed we will allow you to carry a maximum balance of $3000. A lien fee in the amount of $150 will be charged to your account annually from the date of filing.

I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgement of privacy practices.

_____

Print Name **Signature of Patient Or Responsible Party** **Date**

_____

Witness Printed Name **Signature of Witness** **Date**

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Please list your primary symptoms or concerns:

_____
_____

What aggravates your symptoms or condition?:

_____
_____

What makes your symptoms better?:

_____
_____

General Health: ❒ **Excellent** ❒ **Good** ❒ **Average** ❒ **Fair** ❒ **Poor**

Previous Functional level:	**Current functional level:**
❒ Independent in all activities with no difficulty (Work, community, home, leisure)	❒ Independent in all activities with no difficulty (Work, community, home, leisure)
❒ I completed all activities but with some difficulty	❒ I complete all activities but with some difficulty
❒ I completed some work, community, and leisure activities but was independent in self-care	❒ I complete some work, community, and leisure activities but am independent in self-care
❒ I had difficulty performing self-care activities	❒ I have difficulty performing self-care activities
❒ I needed some assistance with self-care activities	❒ I need some assistance with self-care activities

Do you exercise beyond your normal daily activities? ❒ 5+ days/wk ❒ 3-4 days/wk ❒ 1-2 days/wk ❒ occasionally ❒ zero

What is your general stress level? ❒ Low ❒ Medium ❒ High

Do you consume caffeine? ❒ None ❒ Occasional ❒ Moderate ❒ High

Do you consume alcohol? ❒ None ❒ Occasional ❒ Moderate ❒ High

Do you smoke? ❒ Never ❒ Former smoker ❒ Current - how much/often_____
❒ Tobacco ❒ Marijuana

Surgical History:

Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____

Medical History: Have you ever had or been diagnosed with any of the following:

❒ Arthritis
❒ Asthma or shortness of breath
❒ Balance problems
❒ Cancer
❒ Circulation/Vascular Problems
❒ Depression
❒ Diabetes
❒ Headaches/migraine
❒ Head Injuries
❒ Heart problems
❒ Hepatitis
❒ High Blood Pressure
❒ Liver or Kidney disease
❒ Muscle/Joint/Bone
❒ Neurological or Seizure disorders
❒ Recent or recurring Infections
❒ Rheumatological diseases
❒ Stroke