INDEPENDENCE Spine & Orthopedic

Initial Evaluation Intake

Name: _____ DOB: ____ /____ /____

Daytime/Preferred Phone #: _____ Email: _____

Preferred Means of Contact (please check): Phone? _____ OR Email? _____

Home Address: _____

City/State/Zip: _____

Emergency Contact(s): _____ Phone: _____

Reason for Visit/Symptom Location(s): _____

Diagnosis on Prescription (if applicable): _____

Referring Physician (if applicable): _____

Did you have surgery? Yes____ No____ If Yes, When? _____

Surgical Procedure (if known): _____

In Transcend Fitness Club: 591 Durham Rd Suite A, Newtown, PA 18940
In Wrightstown Family Medicine: 2189 Second Street Pike, Newtown, PA 18940

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Consent and Authorization for Physical Therapy Services

Consent for Treatment: I consent to receive services from Independence Spine & Orthopedic Physical Therapy, which may be in the form of: Patient Education, Postural Advice, Therapeutic Exercise Prescription, and Manual Therapy. All services will be provided by **Richard Winters, PT, DPT, CSCS, Cert. MDT.**

Yes: ____ No: ____

Authorization for Payment: I consent to provide payment in the form of cash, check, or credit/debit card beforehand, or on the same day physical therapy services are rendered. I acknowledge it is my responsibility to contact my insurance company prior to treatment to determine whether out-of-network physical therapy services are reimbursed. If so, I will submit the Superbill provided by Independence Spine & Orthopedic.

Yes: ____ No: ____

Authorization for Release of Medical Records: I authorize Independence Spine & Orthopedic Physical Therapy to release medical or other important information for the purposes of processing an out-of-network insurance claim, or to discuss pertinent findings with a qualified healthcare professional (Orthopedist, Primary Care Provider, Neurologist, etc.).

Yes: ____ No: ____

Signature: _____ Print: _____ Date: _____

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Cancellation/Attendance Policies

If you cancel your appointment **less than 24 hours** before it is scheduled to occur, you will be subject to a **fee of $30.00**. In order to avoid a fee, please provide a **cancellation notice** at least 24 hours prior to your appointment.

Independence Spine & Orthopedic schedules only **one patient** every 45 minutes. This helps me to provide thorough and individualized **one-on-one** care to every patient. A late cancellation prevents me from offering that particular time to another patient.

In addition to honoring your scheduled appointment times, I encourage you to arrive **on-time** as best possible. Given that each patient is scheduled every 45 minutes, a late arrival disrupts my ability to provide timely, effective and efficient care, and may lead to your appointment time being cut short to prepare for the next patient.

If it's your first appointment, I would encourage you to arrive at least **10-15 minutes early** to ensure the necessary paperwork is completed. This ultimately leads to the maximum amount of time to be dedicated to the actual examination versus filling out paperwork. Thanks!

Signature: _____ Date: _____

Your signature above acknowledges that you have been both informed of my policies and understand your responsibility.

What to Bring to your First Appointment

1. Completed New Patient Forms (Intake, Consent, Attendance Policies)
2. Completed Functional Questionnaires(s)
3. Physical Therapy Prescription/Referral (if applicable)
4. Picture ID
5. Workout attire and footwear is ideal
6. *Post-operative Therapy Protocol (if given one by your surgeon)*

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