Phone | 972-899-3473 | Fax: 469-784-9424
Email: info@onpointmvp.com | website: www.onpointmvp.com

INTAKE FORM

Name_____ DATE OF BIRTH____/_____/_____

SEX: M F Email: _____

HOME ADDRESS: _____ Apt #_____

CITY _____STATE_____ ZIP _____

HOME TELEPHONE #: (____)_____Cell Phone # (____)_____

EMERGENCY CONTACT _____ TEL #:_____

Please email images FRONT AND BACK of insurance cards to info@onpointmvp.com if possible.

Medicare/Insurance name and ID #: _____, _____

Phone # on back of insurance card: _____

Secondary insurance name ID #: _____, _____

Name on Card: _____; ID #:_____; Group #_____

Phone # on back of insurance card_____

Referring MD or PCP: _____

Phone #_____ FAX #_____

Address: _____

Dates of Hospitalization in past year: _____

Dates of Home Health, under Medicare Part A in past year: _____

Dates Prior Therapy received in past year: _____

Your personal goals for therapy? Pain, balance, strength?_____

_____

How has your function changed with your problem?_____

_____

Patinet/Client/Authorized Representiave Initials _____

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MOVEMENT AND PERFORMANCE

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Current Medications: *May also email an image to info@onpointmvp.com*

_____
_____
_____

Medical History

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease/ heart attack
5. Chest discomfort
6. Heart murmur/ valve disease
7. Shortness of breath
8. Swollen ankles
9. Palpitations
10. Lightheadedness / Dizziness
11. Rheumatic fever
12. Asthma
13. Persistent swollen glands
14. Hearing problems
15. Bone fractures
16. Depression
17. COVID
18. History of fall. How many episodes did you have in the past 12 months____?
19. Bronchitis
20. Pneumonia
21. Persistent cough
22. Tuberculosis
23. Hay fever
24. Sinusitis
25. Abdominal discomfort
26. Indigestion/heartburn
27. Nausea
28. Vomiting
29. Diarrhea
30. Blood in stool
31. Constipation
32. Vision problems
33. Other: _____
34. Other: _____

Informed Consent Form

Physical, Occupational, and Speech Therapy involves several methods of evaluation and treatment. We use a variety of procedures and treatments to help us try and improve your physical and psychosocial function. As with all forms of medical treatment, there are benefits and risks involved. Patient responses to a specific form of treatment can vary widely from patient to patient, and it is not always possible to predict responses to a given form of treatment. There is a risk that your treatment may result in pain, injury, or aggravation of a previous condition.

Wellness services will include methods of screening and what is called performance care segments (PCS). These PCS will be implemented by an expert practitioner. As with all forms of exercise, there are benefits and risks involved. Patient responses to a specific form of exercise can vary widely from client to client, and it is not always possible to predict responses to a given form of treatment. There is a risk that your treatment may result in pain, injury, or aggravation of a previous condition.

Release of Information: I hereby authorize the release of any information by telephone, email/fax, or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by **On Point Movement & Performance, DBA** to the physician

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who referred me for therapy and to any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Notice of Privacy Practices: I acknowledge receipt of the Notice of Privacy Practices from **On Point Movement & Performance, DBA**. I understand that the Notice of Privacy Practices provides information about how **On Point Movement & Performance, DBA** may use and disclose my protected health information. I have reviewed it and understand that the Notice of Privacy Practices is subject to change. View online: https://onpointmvp.com/privacy-policy/

Consent for Treatment: I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of **On Point Movement & Performance, DBA.**

Guarantee of Account: I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by Medicare, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation. I understand that the client's responsibility portion of my bill shall be due and payable at the time of services. I understand that I am personally responsible for full payment of all charges including Medicare denials, deductibles, and copayment fees. I understand that **On Point Movement & Performance, DBA** does not submit to any other insurances, unless negotiated prior to the start of service. I understand that I will be provided with an invoice for services not covered by Medicare which I can submit to my own insurance for reimbursement. in consideration of services rendered to me by **On Point Movement & Performance, DBA**

Medicare/Insurance
I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare/Insurance Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance. I understand that I cannot receive Medicare Part B services in the home if I am currently on Home Health under Medicare Part A and or on Hospice Care. I understand that services must be skilled and medically necessary to be covered by Medicare Part B. I understand Medicare will pay for 80% of the allowed amount, and I am responsible for the remaining 20% if I do not have secondary insurance. (Good Faith Estimate is $20-$30 per visit) if I do not have secondary insurance or if my secondary insurance does not cover the 20% due to policy limitations. Insurance Good Faith estimate: not to exceed more than $250 per visit.

I, _____, by signing this document, acknowledge my consent to the above.

Patient/Client/Authorized Representative Name:_____

Signature: _____ Date: _____

Patinet/Client/Authorized Representiave Initials _____