6631 East 2nd Street Casper, WY 82609
Phone: 307-268-9904
Fax: 307-268-9907
evolvehealthservices.com

NEW PATIENT INTAKE PACKET

How did you hear about us? ____

First Name: ____________________ Last Name: ____________________ Middle Initial: _______

Preferred Name: ______________________________ Date of Birth: ____________________

Gender: ____________ Marital Status: ________________ Social Security Number: ________________

Address: ____

City: ____________________ State: ________________ Zip Code: ____________________

Home Phone: ______________ Cell Phone: ________________ Work Phone: ______________

Email: ____

How would you like your appointment reminders? Check one ▢ Text ▢ Phone Call

Please provide insurance cards for staff to copy.

Insurance Company: ______________________________ Policy Number: ____________________

Name of the Insured: ______________________________ Insured Individual's DOB: ______________

In case of an emergency, who should we contact?

Name: ____

Relationship: ________________________ Phone Number: ________________________

Employer Name/ Address: ____

Employer Phone Number: ______________________ Occupation:______________________

Referring/Ordering Provider: ____

Primary Care Provider: ____

Are you receiving any in-home care services? Circle one. ▢ Yes ▢ No

Please describe your Injury or chief complaint (reason for coming to Evolve Health Services):

____

Date of injury/ onset of symptoms: ______________________ Date of surgery: ______________________

Was this a work related injury? ▢ Yes ▢ No Auto Accident? ▢Yes ▢ No

Surgery? ▢ Yes ▢ No Fall? ▢ Yes ▢ No

If this is a work related injury, what is your Worker's Compensation Number? ______________________

PATIENT MEDICAL HISTORY

Have you been diagnosed or have a history of any of the following? Circle Yes or No.

Alcohol/ Drug Use	YES	NO	Headaches	YES	NO
Allergies	YES	NO	Head Injury	YES	NO
Anemia	YES	NO	Hernia	YES	NO
Anxiety	YES	NO	Heart Condition(s)/ Heart Attack	YES	NO
Arthritis	YES	NO	High Blood Pressure	YES	NO
Asthma/Breathing DIfficulties	YES	NO	High Cholesterol	YES	NO
Blood Clot/ DVT's	YES	NO	Hypo/hyperthyroidism	YES	NO
Bowel/ Bladder Problems	YES	NO	Incontinence	YES	NO
Cardiac Conditions/Disease/Pacemaker	YES	NO	Infection	YES	NO
Cancer	YES	NO	Involved in a Motor Vehicle Accident (MVA)	YES	NO
Circulation/Vascular Problems	YES	NO	Kidney Problems/ Disease	YES	NO
Chronic Neck Pain	YES	NO	Metal Implants	YES	NO
Chronic Back Pain	YES	NO	Multiple Sclerosis	YES	NO
COPD	YES	NO	Neurological Disorders/ Injury	YES	NO
Currently Pregnant	YES	NO	Neuropathy	YES	NO
Given birth/ have children	YES	NO	Numbness/Tingling	YES	NO
Defibrillator	YES	NO	Obesity	YES	NO

Condition			Condition		
Depression	YES	NO	Osteoporosis/Osteopenia	YES	NO
Diabetes	YES	NO	Pain Syndromes/ CRPS	YES	NO
Dizziness/Fainting/Ringing in the Ears/Vertigo	YES	NO	Parkinson's	YES	NO
Double Vision	YES	NO	Psychological/ Mental health diagnosis	YES	NO
Developmental Conditions/Congenital Conditions	YES	NO	Seizures	YES	NO
Degenerative Joint Disease	YES	NO	Speech/ Swallowing Difficulties	YES	NO
Emphysema/Chronic Bronchitis	YES	NO	Sexual Dysfunction/Difficulties	YES	NO
Fibromyalgia/Chronic Fatigue	YES	NO	Stroke/ TIA	YES	NO
Fractures	YES	NO	Sleep Disturbances	YES	NO
Fevers/ Nausea	YES	NO	Skin Disorder/Disease	YES	NO
Gastrointestinal Problems	YES	NO	Smoking	YES	NO
GERD	YES	NO	Spinal Cord Injury	YES	NO
Gallbladder Problems	YES	NO	Thyroid Problems	YES	NO
Groin Numbness	YES	NO	Unexplained Weight Loss/Gain	YES	NO
Headaches/ Migraines	YES	NO	Vision Problems/Changes	YES	NO
Hepatitis/ other Infectious Diseases	YES	NO	Long Term Effects of COVID- 19	YES	NO

List any other health conditions to be aware of (psychological conditions, other medical diagnoses not listed above):____

Please List Your Past Surgical History (starting with the most recent, specific site, date and surgeon):

____

Have you been treated for this condition before? ▢ Yes ▢ No If yes, where? And when?

____

Medications: Please list here or provide a copy of all **CURRENT** medications: ______________________

____

____

Do you have any Drug Allergies? ▢ No ▢ Yes If yes, please list: ________________________________

____

Family History:

Mother: ▢ Alive; Current Age:__________ ▢ Deceased; Cause of Death: ______________________

Health concerns/conditions: ____

Father: ▢ Alive; Current Age:__________ ▢ Deceased; Cause of Death: ______________________

Health concerns/conditions: ____

Siblings: Number of Brothers: ______________ Number of Sisters: ________________

Health concerns/conditions: ____

Health Habits and Lifestyle:

Do you eat a well-balanced diet?	YES	NO	Do you smoke? If yes, the amount per day? __________	YES	NO
Do you drink water regularly?	YES	NO	Do you drink alcohol? If yes, the amount per day? __________	YES	NO
Do you exercise regularly?	YES	NO	Do you have healthy relationships?	YES	NO
Do you have any hobbies/leisure activities?	YES	NO	Do you feel financially stable?	YES	NO
Do you get enough sleep? On average how many hours/night? __________________________	YES	NO	Do you feel your medical needs are being met?	YES	NO

Are you currently working? If so what is your occupation:__________________________________

How is your stress level related to your job? ▢ Low ▢ Medium ▢ High ▢ Extreme

Please indicate the type of residence you currently have:

▢ House/townhouse ▢ Apartment/ Condo ▢ Mobile Home ▢ Other: ___________________________

Number of steps to enter your home: ______________ Number of steps within the home: ________________

Who currently lives with you at home: ____

What are your goals? ____

PAIN

Rate your pain on a scale from 0-10 (0=NO PAIN, 5= MODERATE PAIN, 10= WORST IMAGINABLE PAIN)

Please rate your **CURRENT** pain level:	Which of the following best describes your pain? Check **ALL** that apply.
0 1 2 3 4 5 6 7 8 9 10	
Please rate your **BEST** pain level:	
0 1 2 3 4 5 6 7 8 9 10	▢ Sharp ▢ Achy ▢ Burning
Please rate your **WORST** pain level:	▢ Tingling ▢ Numbness
0 1 2 3 4 5 6 7 8 9 10	▢ Other:________________________

List things that aggravate your pain (makes it worse): ____

____

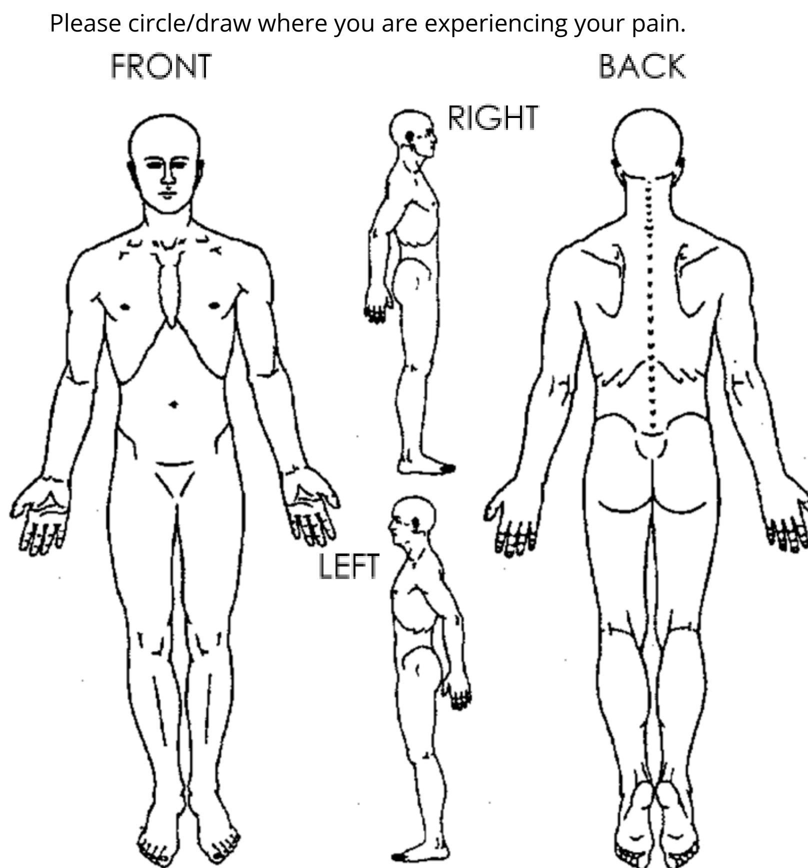
List things that alleviate your pain (makes it better): ____

____

Have you had any diagnostic testing for this injury/ issue? Check all that apply.

▢ X-Ray ▢ MRI ▢ CT Scan ▢ Doppler ▢ Ultrasound ▢ Other: ____________________

Please circle/draw where you are experiencing your pain.



EVOLVE HEALTH SERVICES CONSENT TO TREATMENT

The patient authorizes Evolve Health Service's providers to examine and treat the condition as he/she deems appropriate, and the patient gives the authorization for these procedures to be performed. The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending provider. The patient will not hold the providers responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. The patient shall be advised if Evolve Health Services proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I hereby consent to receive services from Evolve Health Services. I have read (or have, had read to me) the above information and understand the content.

Patient Name: ____ Date: ____________________

Patient's Signature or Authorized Representative: ____

Relationship to the Patient (if other than the patient): ____

***Evolve Health Services Representative Signature/ Date:**____

EVOLVE HEALTH SERVICES NOTICE OF PATIENT PRIVACY PRACTICES

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect clients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your personal health information may be used by Evolve Health Services for treatment, obtaining payment, during an audit, in emergencies, or when required by law. You will be asked for written authorization to use their personal medical information for any other reason than those listed above. You have the right to review their personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of their health privacy to the US Department of Health and Human Services.

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Patient Name: ____ Date: ____________________

Patient's Signature or Authorized Representative: ____

Relationship to the Patient (if other than the patient): ____

EVOLVE HEALTH SERVICES FINANCIAL POLICY

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, coinsurance and deductibles at the time of each visit. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month.

PATIENT'S RESPONSIBILITY

- It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status.
- It is the patient's responsibility to understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for services.
- Pay co-pays, co-insurances, and/or deductibles at time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescription for therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days previous to their 1st visit.
- It is the patient's understanding that a no show fee will be applied for an evaluation of $150.00 and $75.00 for a regular follow up appointment if not canceled/rescheduled within 24 hours prior to scheduled appointment time.
- As a patient, I understand the importance of attending scheduled appointments, if there is a lapse in care on the patient's behalf, the patient may be removed from the schedule by discretion of Evolve Health Services Staff.

Initial: _____________

INSURANCE PATIENTS ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Evolve Health Services to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Evolve Health Services.

Initial: _____________

MEDICARE PATIENTS

Have you had any therapy this year provided in your home or in another outpatient clinic? Yes / No

Do you currently have Medicare home services? Yes / No Medicare ID: ____

SELF PAY PATIENTS

For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. Initial: _____________

VOLUNTARY TERMINATION OF TREATMENT

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

Initial: _____________

I have read the above information and I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient Name: ____ Date: ________________________

Patient Signature or Authorized Representative: ____

Relationship to the patient (if other than the patient): ____