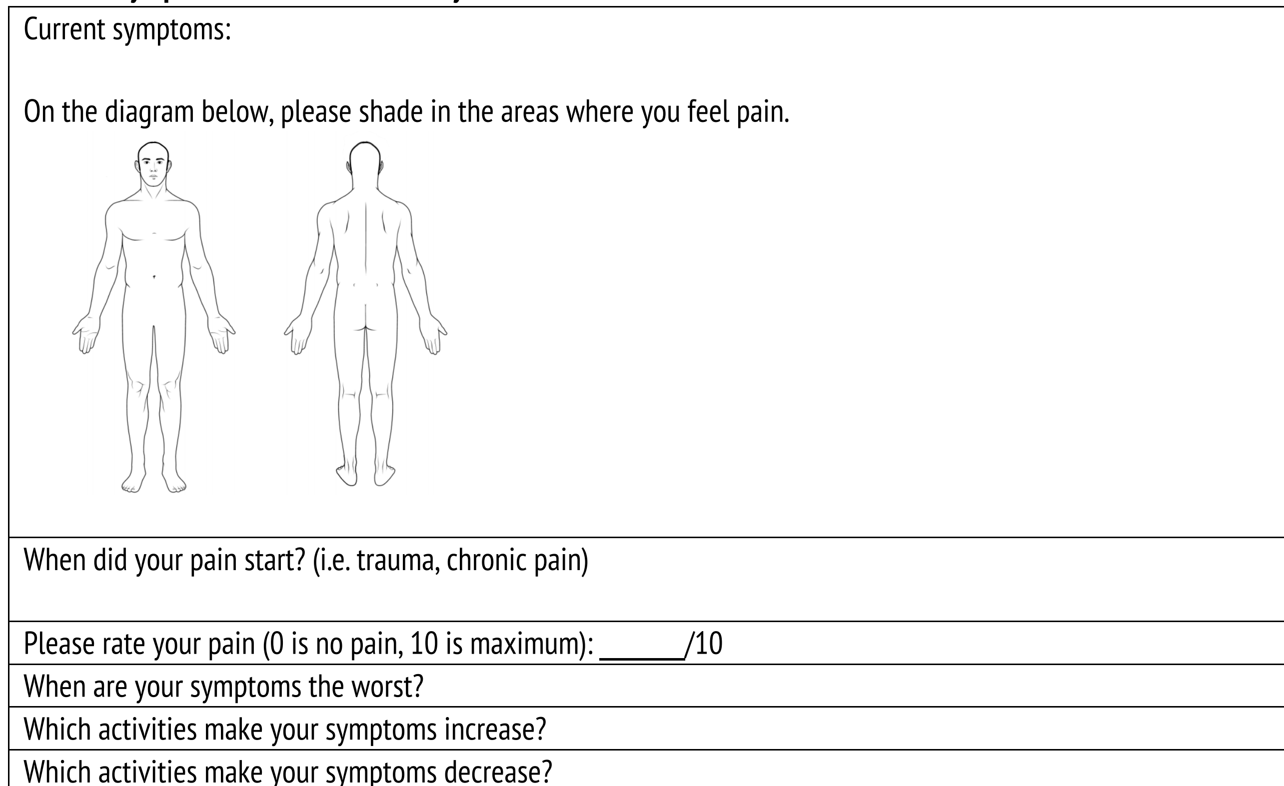
Brittney Mims, PT, DPT
Mims Method

New Patient Intake Form

General Information

Name:	
Date of Birth:	Age:
SSN:	Phone number:
Street Address:	Apt #:
City/State/Zip:	
Occupation:	
Current Exercise Habits (type/frequency):	
Goals for treatment (i.e. decrease pain, improve posture, increase flexibility, increase strength, return to sport):	
Emergency Contact Name:	Phone number:
Referring Medical Doctor:	Phone number:

Current Symptoms and Medical History



Current symptoms: On the diagram below, please shade in the areas where you feel pain.
When did your pain start? (i.e. trauma, chronic pain)
Please rate your pain (0 is no pain, 10 is maximum): ______/10
When are your symptoms the worst?
Which activities make your symptoms increase?
Which activities make your symptoms decrease?

Age: Height: Weight:
Current Medications:
Please list any diagnostic testing that have been performed for your current condition (i.e. MRI, X-Ray, NCV/EMG):
Have you received Physical Therapy for your current condition? If so, where and for how long?
Have you received any other treatment for your current condition? (i.e. massage, chiropractic, acupuncture)
Dance/Sport Requirements:
Is your injury work related?
Does your occupation consist of ____sitting ___standing ____walking ____lifting parterning ___jumping ____dancing in high heels ___ wearing large costumes/props
Please list past surgeries and dates:
Are you currently pregnant? __ Yes __ No Previous births: _____ (vaginal, cesarean)
Please circle any that may apply: Diabetes Fractures Arthritis High Blood Pressure Seizures Asthma Chronic Illness Heart Disorders Pregnancy Stenosis Muscle Cramps Osteoporosis Vertigo Scoliosis Back Pain Cancer Depression Anxiety Concussion Chemical dependency
Any other information you would like to share:

Payments and Billing

Benefits Disclaimer:

Brittney Mims, PT, DPT does not participate in-network with any insurance. It is the patient/insured person's sole responsibility to contact their insurance to confirm his or her out-of-network outpatient physical therapy benefits. Brittney Mims, PT, DPT and/or associated billers may contact your insurance prior to your initial visit to verify coverage. **Verification is not a guarantee of payment by the insurance company.** Patients are expected to know their plan benefits and limitations prior to their initial visit. Co-insurance and deductibles are to be paid at the time of service. If insurance was pre-verified by Brittney Mims, PT, DPT and/or associated billers and your credit card information is on file for payment purposes, claims will be submitted on the patient's behalf. The patient pays the co-insurance at the time of visit and the insurance company will pay Brittney Mims, PT, DPT directly. If the patient is reimbursed by insurance, he or she agrees to pay Brittney Mims, PT,DPT any and all reimbursement. **Any charges not covered by the insurance company are the responsibility of the patient.**

Please sign below to authorize us to bill your insurance company and to acknowledge that you understand the above information along with your financial responsibility.

I, ____________________ hereby authorize Brtitney Mims, PT, DPT to charge my credit card for co-insurance, deductibles and any other unpaid balances over 30 days. All information will be kept confidential as required by our federal privacy policies.

Patient Signature: Date:

Consent for Treatment and Communication:

My signature is required below to authorize treatment. My signature also authorizes the release of my medical information (including but not limited to my physician, insurance company, related healthcare provider, nurse case manager, attorney, assignees, beneficiaries, and all other related persons to my treatment) that is needed to process my claim. We reserve the right to change our policies without prior notice. I am aware of my diagnosis and voluntarily consent to treatment at this practice. No guarantees have been made to me about the outcome of care provided at this practice. Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 2-3 days, I agree to contact my therapist. I agree to pay for the services rendered and to cooperate in providing information necessary to process my claims(s) with third-party payers. A photo carbon copy of this agreement shall be as effective and valid as the original. All information provided on this document is accurate to the best of my knowledge.

Cancellations must be made 24 hours (48 hours if scheduled at Studio 26) in advance or client will be charged for full session. All late cancellation, missed appointment or no show charges are due in full at your next visit. **Your insurance company will not pay for any cancellation charges due to missed appointments.**

I have read the above information and agree to the financial, scheduling, and cancellation policies.

Patient Signature: Date:

Acknowledgement of Risk and Waiver of Liability

I understand that I,______________________________, may be participating in a health and fitness program with Brittney Mims, PT, DPT that will require physical exertion. Before beginning this program, I was asked by my therapist whether I have any physical limitations, or whether I am taking any medications or receiving any medical treatment that might make it unsafe for me to participate in a fitness program. There is no such limitation, medication, or medical treatment other than those I have written on the attached sheet. By signing this sheet, I have obtained permission by my physician to participate in an exercise program.

I understand that, by signing this statement, I am agreeing to not hold Brittney Mims or any of its employees, owners, agents, or insurers responsible for any bodily injury or property damage that may suffer as a result of my participation in a health and fitness program. As such, I understand and agree that Brittney Mims, its employees, owners, agents, or insurers shall not be liable for any bodily injury or property damage that may result either directly or indirectly from my participation in a health and fitness program.

Patient Signature: Date:

Credit Card Information (to be stored on file)

Name on card (please print):	
Type of Card:	
Card Number:	
Expiration Date: ______/_______	CVV:

Primary Insurance Information

Subscriber's Name:	DOB:
Insurance:	ID Number:
Co-pay/Co-insurance:	Group Number:
Deductible:	

Worker's Compensation Information

Subscriber's Name:	DOB:
Employer:	Employer's Phone Number:
Employer's Address:	
Claim number:	
Adjuster contact information:	