



Gaithersburg Regenerative Medicine and Laser Center
60 Market Street, Suite 202 • Gaithersburg, MD 20878 • 301-330-5666

Patient Intake Form

Please take a few minutes to answer the following questions about your health and lifestyle to assist us in expediting your evaluation:

Date: _____ Patient's Name: _____

Age: _____ Height: _____ Weight: _____ Primary Care Physician: _____

Last appointment with Physician: _____ within 6 months _____ within past year _____ more than 1 year ago

How do you learn best? _____ verbally _____ written _____ visually _____ demonstration and practice

What is the reason you are coming to Physical Therapy? _____

When did your symptoms begin? _____

Are your symptoms the result of: _____ accident _____ injury _____ recent surgery _____ slow onset

Diagnostic Tests: _____ X-ray _____ MRI _____ CT-scan _____ other: _____

Have you seen a medical doctor about your concerns, and, if so, what are your understandings about the diagnosis? Yes / No _____

What treatments have you already tried for your current issue? _____ ice _____ heat _____ rest

other: _____

Living conditions: _____ apartment _____ house _____ multiple family dwelling _____

_____ flights of stairs: # _____ railing on stairs: _____ right side _____ left side _____ both

elevator _____ live alone _____ live with family _____ live with others

What is your occupation? _____

If you currently take any medication or supplements on a regular basis, please list medication and reason for medication: _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I have been allowed my free choice in the selection of a rehab/ wellness provider and have been allowed to exercise that free choice. I voluntarily consent to receive rehab/ wellness services.

Patient Signature: _____ Date: _____

Patient Financial Agreement

Welcome to Gaithersburg Regenerative Medicine and Laser Center. We provide physical therapy and wellness services for a variety of medical problems. Some insurance companies may require a script from your physician, dentist, or podiatrist in order to cover your PT services. These scripts are generally valid for 1 month and should be provided to us on your first visit, if needed. If you are planning to submit to your insurance company for reimbursement, please contact them and ask for your out-of-network benefits and whether a script is necessary. You can use your flex spending/ HSA to pay for your services. Patients who have Medicare as part of their insurance plan cannot submit for reimbursement. Fitness and wellness services are provided for Medicare patients, and if the need for skilled PT intervention arises, a referral to a Medicare-contracted provider will be offered.

- Appointments will usually last 25-30 minutes (\$90) or 50-60 minutes (\$180).
- Shockwave therapy is an additional service that has an added cost. Each shockwave session is an additional \$60 charge. A 25-30 minute PT session with shockwave is \$150 and a 50-60 minute PT session with shockwave is \$240
- Please arrive 15 minutes early for your first appointment to complete intake paperwork.
- Please arrive promptly for each scheduled follow up appointment. If you are more than 10 minutes late, your therapist's schedule may prevent you from being seen or your treatment time will be limited.
- Gaithersburg Regenerative Medicine and Laser Center requires 24 hour notice of cancellation of a scheduled appointment. You may be financially responsible for later cancellations and missed appointments (no-shows). We reserve the right to charge for time reserved without proper cancellation. The cancellation fee is \$50.

I understand and agree that I am financially responsible for full payment of my bill. _____(Initial)

I understand that the cost of therapy is dependent on the duration of the appointment and additional services that I may agree to have as part of my treatments. _____(Initial)

I consent to this agreement as of the _____ day of _____, 2022 .

_____(Patient's Name, Printed)

_____(Patient's Signature)

_____(Witness's Name, Printed)

_____(Witness's Signature)