TRITON WELLNESS SOLUTIONS
& SoftWave Therapy

Patient Intake Form

Date: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Date of Birth: _____/_____/_____ Sex: Male Female

Social Security Number: _____ Marital Status: Single Married Partner

Employment Status: Employed Unemployed FT Student PT Student Other_____

How did you hear about our office? _____

Patient Employer Information

Name: _____

Your Occupation: _____

City: _____ State: _____ Zip Code: _____

Spouse Information

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Date of Birth: _____/_____/_____

Emergency Contact (Other Than Spouse)

Contact Name: _____ Relationship to Patient: _____

Contact Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Date of Birth: _____/_____/_____

Primary Care Provider: _____

Payment/Insurance Information:

Who is responsible for your bill? Self / Health Insurance / Spouse / Medicare / Medicaid

Other _____

Personal Health Insurance Carrier: _____

Policy Holder's Name: _____

Insurance Card ID #: _____ Group #: _____

Policy Holder's Date of Birth: _____ / _____ / _____

****Please note SoftWave Therapy is usually not covered by insurance****

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Triton Wellness Solutions and SoftWave Therapy Office's Notice of HIPAA Privacy Practices for protected health information.

Consent to Bill Insurance

I hereby grant permission to Triton Wellness Solutions & SoftWave Therapy to submit medical claims directly to my insurance company for all medical services rendered. I understand that Triton Wellness Solutions & SoftWave Therapy will adhere to all regulations and guidelines set forth by the Health Insurance Portability and Accountability Act (HIPAA) to ensure the protection and confidentiality of my personal and medical information. I understand that I am responsible for any co-pays, deductibles, or charges not covered by my insurance policy. I also understand that failure to fulfill my financial obligations may result in the discontinuation of treatment. I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical benefits to Triton Wellness Solutions & SoftWave Therapy for services provided.

Please Note: This consent will remain in effect until written notice is provided to revoke this consent.

Print Patient's Name: _____

Patient's Signature: _____

Date: _____

Consent to Treat a Minor

I hereby give my consent to Triton Wellness Solutions & SoftWave Therapy and its medical staff to administer medical treatment as deemed necessary to my minor child, in the case of an illness, injury, or other health condition that requires immediate attention.

(Minor's Printed Name): _____

Guardian / Parent Signature Authorizing Care: _____