NEW PATIENT INTAKE FORM

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE FOR PHYSICAL THERAPY

Patient Name: ____

E-mail Address: ____

Street Address: ____

City: ____ State: ______________

Zip Code: ____

Phone #'s (Home, Cell, Work):____

Date of Birth: ____

Diagnosis or Body Part: ____

Referring Physician: ____

Cause of Injury: ____

Name of Insurance Company: ____

IF PATIENT IS NOT THE GUARANTOR ON THE INSURANCE CARD WHAT IS THE NAME, DOB, AND RELATION OF THE GUARANTOR TO THE PATIENT? :

____

In Case of Emergency Please Contact: __________________________________

Phone #: ____

APPOINTMENT REMINDER:

EMAIL ____

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

Signature________________________________ Date___________