NEW PATIENT INTAKE

Patient's Name: ____ Today's Date: _______________
Address: ____City: ______________________State: _____ Zip: _________
Phone: C: (____)_________________ H: (____)_________________ W: (____)__________________
Email: ___________________________________
SS#: ____________________ DOB:____________________ Gender: _______ Marital Status: M S W D

Preferred contact for visit reminders (please circle one):
Email

Voice Call:	Cell Phone	Home Phone	Work Phone
Text Message:	Cell Phone	Home Phone	Work Phone

Custody Status (for minors only): Mother Father Joint Custody Legal Guardian Other: ___________

Referring Physician:________________________ Primary Care Physician (if different): ________________________
Prescription from Doctor? Yes No

Emergency Contact Name: ______________________ Emergency Contact Phone Number: (____)________________

Please list those individuals to whom we are authorized to disclose your private health information (this includes discussing scheduling, treatment, and billing). You do not need to list your doctors. If you would like any private health information shared with your emergency contact in a non-emergency, please list them here as well: ____
____

If you would like to limit the information given to them, please specify here (i.e. only scheduling information):
____

How did you hear about Summit Physical Therapy, Inc.? ____

Are you a Full Time Student? Yes No
Employer:________________________________ Address:_______________________ Job Title: _______________

Is Patient the Responsible Party? Yes No
If no: Responsible Party Name:________________________________ Relationship to patient:________________
Address: ____SS#:_____-_____-_____ DOB:_____________

Is this a work- related accident / injury? Yes No Date of Injury: ___/___/___ If Surgery, the date: ___/___/___
Employer at time of injury: ____*Phone #:* _______________________
Address: ____
*Work Comp. Provider Ins .:*____ *Phone #:*________________________
*Work Comp. Claim #:*________________________________ *Adjuster:*___________________________________
Have you returned to work? Yes No Please list work restrictions, if any: _________________________________
____

Was this injury caused by a motor vehicle accident? YES / NO Please list details of accident: ___________________________________
____
____

Insurance Information

Primary Insurance Co: ________________________________ Group#:_______________ Id#: __________________
Primary Insured Party Name:___________________________________ DOB: __________ SS#:______:______:____
Relationship to patient: _________________________________ Phone #: ____________________________
Address: ____

Secondary Insurance Co: ______________________________ Group#:_______________ Id#: __________________
Primary Insured Party Name:___________________________________ DOB: __________ SS#:______:______:____
Relationship to patient: _________________________________ Phone #: ____________________________
Address: ____

Have you had Physical Therapy or Speech Therapy this year? Yes No
If yes, where? ____

I, the patient, do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment as ordered by the prescribing physician, and his/her assistant(s), and consultant(s), as is necessary in his/her professional judgment. I assume responsibility for discussing and understanding my proposed treatment and goals based on the evaluation with my physician, as well as expected benefits and potential risks and drawbacks of the evaluation and service, and understand treatment does not guarantee an improvement in my current condition.

Please initial _________

I hereby authorize Summit Physical Therapy, Inc., its employees or agents, to release medical information regarding myself and my current condition(s) to my insurance company for purposes of payment and/or quality reviews; and referring, consulting, treating physicians, or other medical providers as necessary to support continuity of care. This authorization will remain valid until mutually revoked in writing by both the patient and Summit Physical Therapy, Inc. I understand that Summit Physical Therapy, Inc. has made a copy of their Notice of Privacy Practices available for my review, and that I can request a copy at any time in writing or by contacting a Summit Physical Therapy, Inc. office representative. I authorize Summit Physical Therapy, Inc. to utilize my contact information, such as email addresses or phone numbers, to correspond with me information that is not considered Protected Health Information (PHI).

Please initial _________

I, understand that I am responsible for communicating with my insurance company regarding any co-payments, deductibles, or provider information pertaining to my treatment at Summit Physical Therapy, Inc. I understand that I am responsible for obtaining any required referrals from primary care clinics. I understand I am ultimately responsible for any charges not covered by third party payers. I attest that I am not currently receiving or enrolled in home health services. I agree to notify Summit Physical Therapy, Inc. in writing if I begin home health services, and acknowledge that failure to notify Summit Physical Therapy, Inc. in writing will result in my being financially responsible for services rendered.

Please initial _________

I agree I am responsible for notifying Summit Physical Therapy, Inc. within 30 days of change in insurance coverage, or termination of existing coverage. If I fail to do so within that timeframe, I will be responsible for the full balance due for services rendered. If I notify Summit Physical Therapy, Inc. of new insurance after services have already been rendered, and the new insurance will not cover services due to plan-level requirements not being met (such as but not limited to MD Orders, Prior Authorization), I agree to be responsible for the full balance due of services rendered.

Please initial _________

If applicable, I authorize third party payment directly to Summit Physical Therapy, Inc. of the benefits otherwise payable to me. Those charges are not to exceed charges incurred. If I have instigated litigation due to my injury and refuse to provide the appropriate insurance information, I understand that I am required to pay Summit Physical Therapy, Inc. at the time services are provided. I also understand that if I have filed a Workers Compensation claim and my claim is denied, I will then be responsible for payment of services as they are received if I do not provide health insurance. I understand I am financially responsible to Summit Physical Therapy, Inc. for charges not covered by this authorization.

Please initial _________

I understand that all copayments, coinsurances, and deductibles are paid in full at the time of treatment unless previous arrangements have been made in writing.

Please initial _________

I have read Summit Physical Therapy Inc.'s Privacy Practices Statement (or waive my right to read this document) and understand my privacy rights as they pertain to treatment at Summit Physical Therapy, Inc.

Please initial _________

The information submitted in this form is accurate to the best of my knowledge.

Patient Signature: ____ Date: ____/____/____

Print Patients Name: ____

Responsible Party Signature (if required): ______________________________ Date: ____/____/____

Responsible Party Printed Name: ____

Relationship to Patient: _______________________________________