Patient Intake Form

Date _____**Legal Name**_____

Date of Birth_____ (First) (Last) (Middle)

Address:

_____

(Street) (City) (State) (Zip Code)

Preferred Name Nickname_____

Gender Listed on Insurance _____ Marital Status: Married Divorced Single
Preferred method of communication (You will receive an appointment reminder Email):
Email :_____
Home Phone:_____
Day Phone :_____
Cell Phone :_____
Employer Name _____
Employer phone _____
Employer Headquarters' Address (City/State)

_____

Employer Local Address (City/State)

_____

How did you hear about us? Please specify name/organization so we can thank them:

_____

Do you have a Primary Care Physician? Yes No

Referring Physician/Doctor/Health Care Provider _____

Phone_____Fax:_____
Address_____
Physician's Practice Name: _____
(We will send them copy of evaluation and other notes if necessary)
Insurance Have you verified your therapy benefits with your insurance? (circle one) Yes No
Have you had Physical/Occupational therapy this calendar year? Yes No
How many treatments (include Chiropractic) have you received this calendar year? _____
Former Patient? Yes No

Health Insurance Primary Company_____
ID#_____Group #_____

Policyholder Name_____Relationship_____DOB_____

Secondary Insurance Company_____
ID#_____Group #_____

Policyholder_____Relationship_____DOB_____

Auto Accident Is this an Auto Accident? Yes No Date of Accident:_____
_____ In what City and State did this occur?
_____ Is this a lawsuit? Yes No
Attorney/Firm Name _____
Attorney Phone _____

Work Comp Is this an approved Workers Comp Injury? Yes No
Case Manager Name/Phone:_____
Date of Injury_____ In what City and State did the injury occur? _____
Job Title _____ Attorney/Firm Name _____
Attorney Phone _____
*Please make sure Employer information is filled out on previous page to process your case in timely manner.

List any allergies (i.e. latex, adhesives)_____

Person to contact in case of an emergency (Name, Phone & Relationship):

_____
_____

Body Part or condition that needs attention: ______

REHABON PHYSICAL THERAPY

CONSENT & STATEMENT OF FINANCIAL RESPONSOBILITY

1. CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist and other health care professionals and assistants who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist or other healthcare professionals. .I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, myofascial decompression and blood flow restriction, Assisted Soft Tissue Mobilization, Asytm ® or Graston Technique®, Video Analysis and Video Gait Analysis.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and I understand that cancellation of, or failing to keep, an appointment with less than 24 hours' notice.

3. **WORKER'S COMPENSATION PATIENTS:** I understand that REHABON is required to inform my Worker's Compensation Adjuster and/or Rehabilitation/Case Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled. 3. RESPONSIBILITY FOR PAYMENT: All co-payments and Out of pocket services (i.e., Astym, Graston, etc.) are due at the time of service. I acknowledge that in consideration of the services provided to me by REHABON, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide REHABON with my current insurance information and to familiarize myself with my insurance plan and its policies.

Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to REHABON all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with REHABON and to provide such information as is needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that REHABON may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I acknowledge that I have received REHABON's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Printed Name of Patient/Sign_____ Signature _____

If minor, Parent/guardian's name and signature_____

REHABON complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

REHABON
PHYSICAL THERAPY