NEW PATIENT INTAKE FORM

Date: _____

Last Name:	First Name:
Address:	Apt. or P.O. Box:
City:	State:
Zip Code:	Date of Birth:
Phone Numbers	
Home Phone: ( )	Email:
Work Phone: ( )	Social Security Number:
Cell Phone: ( )	

Emergency Contact

Last Name:	First Name:
Phone: ( )	
Relationship:	

Employer Information

Name of Employer:	
Address:	Suite or Office Number:
City:	State:
Zip Code:	

Problem/Condition

Description of Problem:	
Referred by:	
Referral Information:	
Date of Onset:	

Have you ever been treated by us? Y/N.
Have you had physical therapy, occupational therapy or chiropractic treatment this year? Y/N.
If yes, please indicate the type of treatment and the duration of treatment?_____.
Have you previously had treatment for this condition? Y/N. If yes, for how long?_____.
Have you ever had surgery? Y/N. If yes, please list all surgeries:_____.

CONSENT TO TREATMENT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

Signature of Patient or Legal Guardian:_____ **Date:**____/____/_____

ON THE GO
PHYSICAL THERAPY

FINANCIAL RESPONSIBILITY: I agree to pay my rehabilitation therapy provider ("Provider") all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney's fees.

Signature of Patient or Legal Guardian:_____ **Date:**____/____/_____

ATTENDANCE POLICY: I acknowledge that I read and understand the **Attendance Policy** and agree to abide by its terms and conditions.

Signature of Patient or Legal Guardian:_____ **Date:**____/____/_____

Privacy Practices: I have received a copy of the **HIPAA Notice of Privacy Practices.**

Signature of Patient or Legal Guardian:_____ **Date:**____/____/_____