COMPLETE PHYSICAL / HAND THERAPY THERAPY

New Patient Intake Form

Patient Information

Patient Name: _____ Date of Birth:_____
Last First M.I.

Marital Status: _____ Gender: M F Other
Please Circle

Address: _____
Street City State Zip

Primary Phone: (_____) _____
Please Circle: Cell Home Work

Secondary Phone: (_____) _____
Please Circle: Cell Home Work

Permission to leave Voice Message	Permission to leave Appt. Reminders
Yes No *Please Circle*	Text Email Voice *Please Circle*

Email Address: _____ *(Complete Physical & Hand Therapy will not share, sell or trade your information)*

Emergency Contact: _____ (____)_____ _____
Name Phone # Relationship

Referring Provider: _____ Primary Care Provider:_____

Diagnosis or Chief Complaint: _____ Date of Injury/Onset:_____

Employer: _____ Occupation:_____

Insurance Information

Primary Insurance: _____
ID/Member #: _____
Group#: _____

Secondary Insurance: _____
ID/Member #: _____
Group#: _____

If patient is not the plan policyholder, please complete below

Policyholder Name: _____
Policyholder DOB: _____
Relationship to patient: _____

Policyholder Name: _____
Policyholder DOB: _____
Relationship to patient: _____

Claim Information

Worker's Compensation or Motor Vehicle Accident/Personal Injury Only

Worker's Compensation

Employer: _____
Employer Address: _____
Date of Injury: _____
Claim Number: _____
Claims Manager: _____
Phone Number: _____
Attorney & Phone #: _____

Motor Vehicle/Personal Injury

Insurance: _____
Claim: _____
Date of Injury: _____
Claim Address: _____
Claims Adjuster: _____
Phone Number: _____
Attorney & Phone #: _____

Who can we thank for telling you about Complete Physical & Hand Therapy?_____

OVER ------>

CONSENT TO RECEIVE TREATMENT

By signing below, I agree to the following:
I voluntarily give Complete Physical and Hand Therapy my consent to receive services, which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical and occpational therapy involves manual techniques that require physical contact by the healthcare provider and staff.

Signed: _____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

FINANCIAL POLICY

Upon registration, we ask that you present your photo identification and primary and/or secondary insurance cards. We will scan these documents so that we may appropriately bill your insurance policies. Also, please fully complete our New Patient Intake Form. We will verify your insurance benefits and present to you at your initial visit. Copayments are due at each visit, and if you have a large deductible, we request you make payments at each visit. We will promptly file your claims, and you will receive regular statements from us. All balance are due upon receipt of our statement.

CANCELLATION AND BROKEN APPOINTMENT POLICY

We would like you to be aware of our cancellation and broken appointment policy. Any appointments cancelled or broken with 24 hours of their schedule time may be subject to receiving a $25 fee. If a cancellation is unavoidable, we do ask that you give us a much notice as possible so we may offer that appointment time to another patient.

By signing below, you acknowledge that you have read our policy and understand that your commitment to a successful physical and/or occupational therapy outcome is essential. The cancellation fee is not covered by insurance and will be collected at the time of your next visit.

Signed: _____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT & CONSENT TO DISCLOSE INFORMATION

Our Notice of Privacy Practices brochure describes in detail how your health information may be used and disclosed, and how you can access your information. Please inform the Front Desk Staff if you would like a copy of our brochure. By signing below, you acknowledge how to obtain our Privacy Practices Brochure. You are also authorizing Complete Physical Therapy to release your records to your insurance company and physician. Please understand your records are held in strict confidence and we will not release them to any unauthorized person or entity. Our Notice of Privacy Practices provides further information about how we may use and disclose protected health information.

Signed: _____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information.

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

I authorize Complete Physical & Hand Therapy to discuss my medical and/or billing information with the above-named person(s).

Signed: _____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

Complete Physical & Hand Therapy

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