INITIAL PATIENT INTAKE FORM

NP RETURNING PT

Patient Name: ______________________________

Home Phone: ______________ Work Phone: ______________

Mobile Phone: ______________ Carrier: ______________

Appointment Reminders: **Email** **Call** **Text** **Calendar Invite**

Mailing Address: ______________________________

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Email Address: ______________________________

Patient DOB: ______________ SS # ______________

BODY PART/DX:______________________________

Weight: ____________ Height: ____________ BMI: ____________

How did they hear about Therapy Works: ______________________________

Referring M.D.______________________ Tel:______________

Primary Care M.D.______________________ Tel:______________

Have you had Physical Therapy elsewhere this year? YES NO

Was it for this condition? YES NO When did it end:______________

Emergency Contact Number: ______________________________

Name: ______________________ Relationship: ______________

Surgery (If yes what type) YES NO ______________________________

Date of Surgery: ______________ Do you have a referral? YES NO

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager. With my permission, Therapy Works staff may call or mail my home or other designated locations and leave a message or voicemail, or in person, in reference to appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care.

By signing this form, I am allowing Therapy Works to use and disclose my private health information in order to address treatment, payment or healthcare operations as detailed in the privacy notice.

I may make the following special request for confidential communications:

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I agree to adhere to Therapy Works office policies and I understand that failure to do so may result in my discharge from Therapy Works care.

______________________ ______________________

Print Patient Name Signature of Patient or Legal Guardian if under 18

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Date

Primary Insurance: ____________________

Person Insured____________________

ID No.: ____________________ Group Number: ____________________

Secondary Insurance: ____________________

ID No.: ____________________ Group Number: ____________________

Carrier Name: ____________________ Phone:____________________

PRIMARY INSURANCE DETAILS

Insurance Carrier:____________________ Eff:____________________

Tel:____________________ Co-Payment:____________________

Co-Insurance:____________________ No. Visits/Year:____________________

Visits Used:____________________ Deductible (Ind/Fam):____________________

Deductible Met (Ind/Fam):____________________

Referral Required: YES NO Pre-cert Required: YES NO

Pre-cert Information:____________________

Out of pocket max:____________________ Out of pocket max met:____________________

Therapy Cap: ____________________ Cap Used: ____________________

WC | MVA

Covered Body Part:____________________

Claim Open:____________________ Active:____________________

Adjustor:____________________ Tel:____________________

Fax:____________________ Authorised Visits (WC):____________________

NOTES

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