PATIENT INTAKE FORM

Patient Information

Patient Name: ____________________ DOB: ____________ Sex: ________

Address: ____________________ City: __________ State: __________ Zip: ________

Home Phone #: ____________________ Marital Status: ____________________

Cell Phone #: ____________________ **Would you like to receive text message appointment reminders via your cell phone number?** Yes ☐ No ☐

E-mail address: ______________________________

SSN: ____________________ Drivers License # ____________________

Are you working? Yes ☐ No ☐ Full Time ☐ Part Time ☐ Are you working with restrictions? Yes ☐ No ☐

Name of Employer: ____________________ Phone #: ____________________

Employer Address: ______________________________

Occupation: ______________________________

Date Symptoms / Condition Started: ____________ What was the cause of your condition? ____________________

Have you ever been a patient here before? Yes ☐ No ☐

If no, how did you hear about Progressive Physical Therapy? ____________________

Referring Doctor: ____________________ Phone: ____________________

Primary Care Physician: ____________________ Would you like your Primary Physician to receive copies of your treatment records? Yes ☐ No ☐

Spouse:

Name of Spouse: ____________________ SSN: ____________ DOB: ____________

Spouse's Employer: ______________________________

Emergency Contacts & Disclosures to Individuals Involved in Patient's Care:

I authorize Progressive Physical Therapy PC to disclose my health information that is directly related to my current treatment at Progressive Physical Therapy PC to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

Name: ____________________ Relationship: ____________ Phone: ____________

Name: ____________________ Relationship: ____________ Phone: ____________

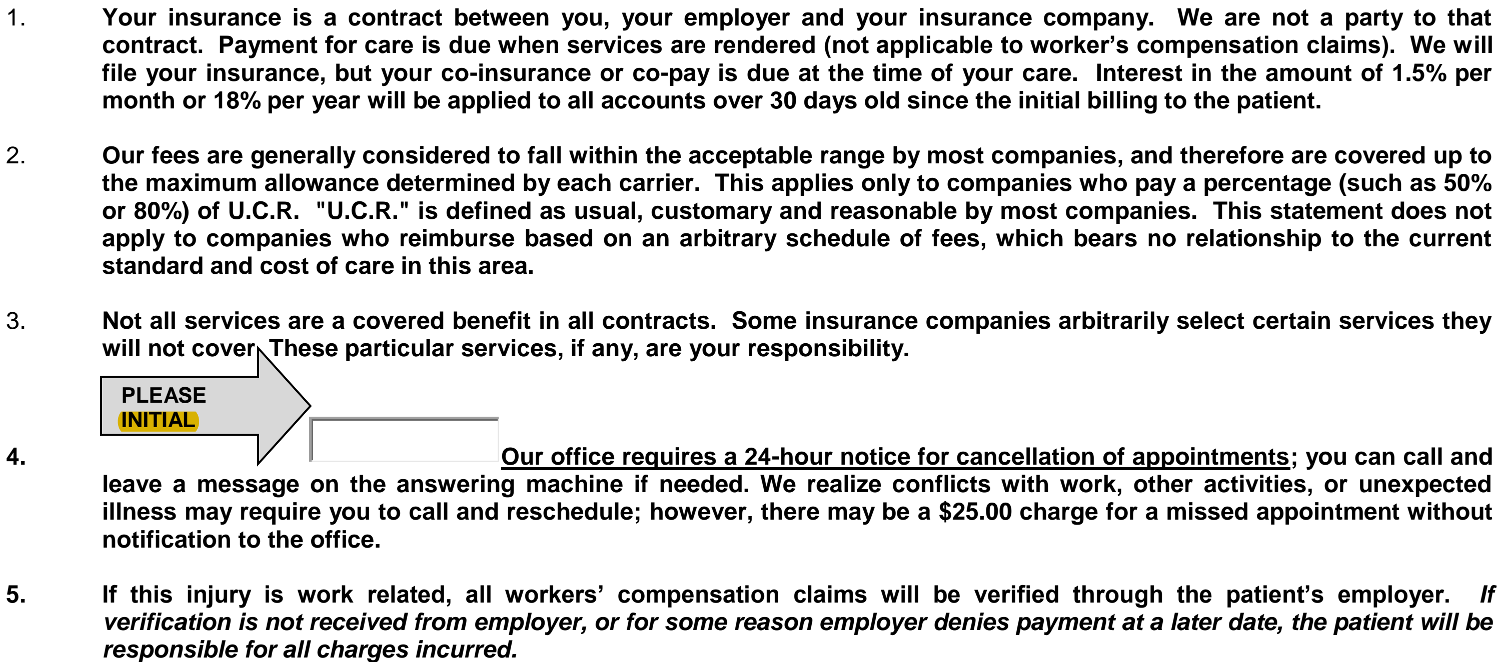
Patient Intake – Page 2 of 3

Progressive Physical Therapy Insurance Policies

	Primary Insurance	Secondary Insurance
Insurance Company		
Address		
Name of Policy Holder		
ID Number		
Plan/Group Number		
Member's Date of Birth		
Work Comp Adjuster or Case Manager (if applicable)		

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, or credit cards (MasterCard, Visa, Discover, American Express, and CareCredit).

Please read carefully:



1. **Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. Payment for care is due when services are rendered (not applicable to worker's compensation claims). We will file your insurance, but your co-insurance or co-pay is due at the time of your care. Interest in the amount of 1.5% per month or 18% per year will be applied to all accounts over 30 days old since the initial billing to the patient.**

2. **Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.**

3. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.**

PLEASE INITIAL

4. **Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule; however, there may be a $25.00 charge for a missed appointment without notification to the office.**

5. **If this injury is work related, all workers' compensation claims will be verified through the patient's employer. *If verification is not received from employer, or for some reason employer denies payment at a later date, the patient will be responsible for all charges incurred.***

Authorization for Release of Information and Financial Agreement

I have read the above policies and agree. I hereby authorize and direct my insurance benefits to be paid directly to Progressive Physical Therapy, P.C. I understand I am financially responsible for services not covered by my insurance. I authorize the release of any information required to process my insurance claim.

I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of ***33 1/3%*** *will be added to my account. I agree to pay that fee. I also agree to pay reasonable attorney fees and court costs. I agree that by providing a cell phone number on this form, I am providing my consent to have you or your agents call me at that number and any number to which it forwards from this date forward. I agree that this statement applies to all current and future claims. I understand and agree to the above terms.*

Printed Name: ______________________________

Signed: ______________________________ Date: ______________

CONSENT FOR TREATMENT

I hereby give my consent for treatment by Progressive Physical Therapy PC

and

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information. I understand that my custom Exercise Sheets and other health related information can be sent to me via my personal e-mail address listed on page 1.

I have read and/or received the Notice of Privacy Practices from Progressive Physical Therapy, PC.

Printed Name: ______________________________

Signed: ______________________________ Date: __________

If Patient is Less Than 18 Years of Age, Parent or Guardian MUST complete this section in addition to the above section:

PATIENT: ______________________________ **PATIENT CURRENT AGE:** __________

Parent or Legal Guardian Name: ______________________________ SSN: __________

Driver's License: __________ Parent or Guardian Employer: ______________________________

I hereby grant PROGRESSIVE PHYSICAL THERAPY P.C. the authorization to render the services of physical therapy to my minor child.

Signature authorizing treatment of minor child: ______________________________ Date: __________

MEDICATIONS

Please check if you are currently taking any of the following types of medications?

☐ Blood Pressure Medication ☐ Blood Thinner Medication ☐ Heart Medication