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:	

Primary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

NEW PATIENT INTAKE FORM

Secondary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

Have you ever been treated at Professional? Y/N. If yes, which location: _____.
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:_____.

For Medicare Patients Only:
Are you currently receiving home care services? **Y/N.** If yes, expected date of completion?_____.
Do you have a home care discharge letter? **Y/N.**

For Student Athletes Only:
What sport(s) does the student athlete play?_____.
Was the student athlete injured during the performance of the sport? **Y/N.** If yes, what date was the student athlete injured?_____.
Was the student athlete injured at school or in a league?_____.
Was any paperwork filed with the school or league? **Y/N.** If yes, please provide the name of the school or the league:_____.

Motor Vehicle Accident Injuries Only: If you are receiving care for injuries from a motor vehicle accident, in what state did the accident occur?_____.

Newsletter:
☐ I would like to receive Professional's Newsletter, which contains information about the company and its services.

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:**____/____/_____

NEW PATIENT INTAKE FORM

AUTHORIZATION TO USE RECORDING DEVICES: In conjunction with my care, I authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing my care. In addition, I authorize the transmittal of such recording device videos and/or images to my rehabilitation provider and/or the treating physician through secure email and/or text message. I acknowledge that such videos and/or images will only be used or disclosed for treatment purposes, and that my rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without my written authorization.

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

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:**____/____/_____

ELECTRICAL STIMULATION PAD POLICY: I acknowledge that I read and understand the **Electrical Stimulation Pad Policy** and agree to abide by its terms and conditions.

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

DIRECT ACCESS LAW POLICY (This section only applies to Connecticut, Massachusetts, New Hampshire, and New Jersey patients receiving rehabilitation therapy without a referral): I confirm that I disclosed or affirmatively confirmed in writing the identity of my primary care provider, health care provider of record, licensed health care professional of record, or health care practitioner to my rehabilitation provider, and I acknowledge that I read and understand the **Direct Access Law Policy** in the state I am receiving rehabilitation therapy and agree to abide by its terms and conditions, and I consent to receive rehabilitation therapy and any supplementary services that are deemed medically necessary or appropriate by my therapist without a referral from an eligible practitioner.

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