P50 PHYSICALTHERAPY

PATIENT INTAKE PACKET

Please print clearly.

PATIENT INFORMATION

Full Name: _____

Preferred Name: _____

Date of Birth: _____ Phone # :_____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Gender (optional): ☐ Female ☐ Male ☐ Prefer not to say

Preffered Method of Contact: ☐ Phone ☐ Text ☐ Email

EMERGENCY CONTACT INFORMATION

Full Name: _____

Relationship: _____ Phone # :_____

INSURANCE INFORMATION

Please present all insurance cards to the front desk.

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Relationship to Patient: _____

Policy / Member ID #: _____ Group # :_____

SECONDARY INSURANCE INFORMATION

If you don't have secondary insurance coverage, you can skip this section.

Insurance Company _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy / Member ID #: _____ Group # :_____

ADULT PATIENT CONSENT AND ACKNOWLEDGMENT

Complete this section only if the patient (you) is 18 years of age or older.

Please initial each section to confirm your understanding and agreement.

_____ CONSENT TO TREAT
I consent to evaluation and treatment by licensed physical therapy professionals. I understand that physical therapy may involve physical movement, manual techniques, and therapeutic exercise.

_____ FINANCIAL RESPONSIBILITY
I understand that I am financially responsible for all charges not covered by insurance, including co-payments, deductibles, non-covered services, and fees outlined in the clinic's policies.

_____ HIPAA ACKNOWLEDGMENT
I acknowledge that I have been offered or received a copy of the clinic's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed in accordance with HIPAA. I understand that I may request a copy of this notice at any time.

ADULT PATIENT SIGNATURE

I certify that the information provided above is accurate and complete to the best of my knowledge.

_____

Patient Signature

Date: _____

GUARDIAN / MINOR CONSENT AND ACKNOWLEDGMENT

Complete for patients under 18 or as required by law.

I, the undersigned, am the parent or legal guardian of the minor patient named above. I authorize evaluation and treatment by licensed physical therapy professionals. I acknowledge that I am responsible for all financial obligations, including co-payments, deductibles, and fees not covered by insurance. I have received or been offered a copy of the clinic's Notice of Privacy Practices and understand that protected health information may be used or disclosed in accordance with HIPAA.

Please initial each section to confirm your understanding and agreement.

_____ CONSENT TO TREAT

I consent to evaluation and treatment by licensed physical therapy professionals. I understand that physical therapy may involve physical movement, manual techniques, and therapeutic exercise.

_____ FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges not covered by insurance, including co-payments, deductibles, non-covered services, and fees outlined in the clinic's policies.

_____ HIPAA ACKNOWLEDGMENT

I acknowledge that I have been offered or received a copy of the clinic's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed in accordance with HIPAA. I understand that I may request a copy of this notice at any time.

_____

Parent / Guardian Name *(Please Print)*

Relationship to Patient: _____

PARENT / LEGAL GUARDIAN SIGNATURE

_____

Parent / Guardian Signature

Date: _____