

Intake Paperwork



Referring MD: _____ Primary Care Physician _____

Name: _____ DOB ____ / ____ / ____ SSN# ____ / ____ / ____

Address: _____ City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Text Cell (____) ____ - ____ email _____

Cell Phone Carrier : (ATT, Verizon, etc...) : _____

Gender _____ Marital Status _____ Employer _____

Job, sport, or activity _____

Emergency Contact Person _____ Emergency Contact # (____) ____ - ____

Date of Injury / Onset _____ Next Physician Appointment Date _____

What body part are you being seen for today? _____ Is this accident related? _____

Is this work related? _____ How did you hear about our clinic? _____

if client is under 18 years of age....

Parent's/Guardian's Name _____ Parent's SSN# ____ / ____ / ____

Parent's Phone (____) ____ - ____ Cell (____) ____ - ____ email _____

For Tricare Insurance, we need the Military Personnel's (primary subscriber's) SSN: ____ / ____ / ____

yes	no	Are you allergic to cortisone?
yes	no	Are you allergic to latex?
yes	no	Do you have a pacemaker?
yes	no	Are you currently having any other outpatient or in-home services?
yes	no	Have you had any in-home services or physical therapy this year?
yes	no	Have you had other physical therapy, chiropractic, occupational therapy, or speech pathology this year?

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CONSENT, DISCLOSURE, AND PRIVACY

I hereby give consent to the physical therapists at Carson Physical Therapy, Inc. to provide physical therapy treatments to myself for conditions warranted by physical therapy treatment.

If I am to have my account paid by health insurance, workman's compensation or auto insurance, I hereby request and authorize my insurance company(s) or Medicare to pay directly to Carson Physical Therapy any proceeds payable under the terms of my policy(s) for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital and physical therapy pre-certifications, deductibles, co-insurance, and co-payment.

It is the policy of Carson Physical Therapy to help the client in obtaining full benefits from his/her insurance company. However, the clinic is not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

I understand that data collected during my visits to therapy may be used for research purposes.
I have been provided an opportunity to review and received a copy of Carson Physical Therapy's privacy policies.

Our office is happy to file medical claims with your insurance carrier. Once we have received payment from your insurance company, any remaining balance on your account not already collected is due and payable within thirty (30) days of receiving the insurance payment. Co-pays are due at time of service. The benefits that we explain to you are only an estimate of benefits. **It is your responsibility to know your insurance policy and how they pay (i.e. your deductible, your copay, and/or co-insurance).**

Carson Physical Therapy also reserved the right to utilize the services of a collection agency in collecting delinquent accounts. If a collection services is utilized, I agree to pay all such costs incurred in collecting my account balance, including attorney's fees. If my check is returned for insufficient funds, I agree to pay a returned check fee of \$25 for each occurrence.

Signature of Client (parent or Guardian if client is under 18 years of age)

Date