Intake Paperwork

Referring MD: ________________________ **Primary Care Physician** ________________________________

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

Address: ___________________________ **City** ______________________ **State** _________ **Zip**_________

Home Phone (____)____-_______ Text Cell (____)____-_______ email ______________________________

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?** _________________________

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

if client is under 18 years of age….

Insurance Holder's Name ____________________________________ **Parent's SSN#** ____ / ____ / _____

Cell (____)____-_______ email ________________________________ **Date of Birth** ____ /_____ / _____

Please answer the following:

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?

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 / collection'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 Date

____
Print Name

____ _______________________
Signature of Parent or Guardian (If Under 18 years of age) Date

____
Print Name

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