# Patient Intake Form

Name: (Dr. /Mr. /Mrs. /Ms.) _____ Date: ____/____/____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Social Security Number: _____-____-_____ Date of Birth: ____/____/____

Person to be notified in case of emergency: _____ _____
(name) (phone number)

Referring Physician: _____ Primary Physician: _____

Have you had previous Physical Therapy within this calendar year? ___ YES ___ No

If Yes, WHEN, WHERE and for WHAT body part? _____
_____

Are you currently receiving any home health services? (i.e. nursing, therapy, lab tests) ___Yes ___ No

Party Responsible for Payment: ___ Self ___ Personal Insurance ___ Workers' Compensation
___ No-Fault ___ Other _____

Insurance Information: (please note that it is your responsibility to provide accurate insurance information)

Personal:

Primary: _____

Secondary: _____

If Work-Related, please provide the following information:

Employer: _____ Occupation: _____

Address: _____ Currently Working: __ Yes __ No

Insurance Carrier: _____

WCB#: _____ Carrier Case #: _____

*I understand that billing of insurance companies is a courtesy, and that I am financially responsible for payment at the time services are rendered. If I do not provide the correct information required for billing, I agree to be personally responsible for all expenses associated with services rendered. Expenses may include interest charges, collection fees, and legal/court costs. I hereby give permission to Howard Physical Therapy, PLLC to administer treatment for my condition and authorize them to release all necessary medical information to parties responsible for payment. I also understand that I may receive Physical Therapy without a prescription from my physician and that my insurance company may deny payment if a prescription is not provided.*

Signature: _____ Date: _____

*Our billing department will attempt to answer any questions regarding your financial responsibility, however, specific questions pertaining to your contract should be directed to your insurance carrier.*