Sabrina Summers, PT DPT IMTC | Wendy Hand, MSPT | Nathan Toney, PT

NEW PATIENT INTAKE FORM

Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ DOB: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Fax #: _____

E-Mail:_____

How would you like to receive appointment reminders?

☐ Home Phone - Call ☐ Mobile Phone - Call ☐ Text Message ☐ Email

Referring MD: _____ Phone: _____

Primary MD: _____ Phone: _____

Diagnosis: _____ Post OP? _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: ID Number:

_____ _____

Insured Name (as it appears on your card): Group Number (if applicable):

_____ _____

DOB of Subscriber (if other than patient): Subscriber Employer:

_____ _____

Secondary Insurance: ID Number:

_____ _____

Insured Name (as it appears on your card): Group Number (if applicable):

_____ _____

DOB of Subscriber (if other than patient): Subscriber Employer:

_____ _____

RESPONSIBLE PARTY STATEMENT/ASSIGNMENT OF BENEFITS

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

I hereby assign all medical benefits to which I am entitled to Align Physical Therapy Group in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing and any additional fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month or 18% annually for unpaid balances over 60 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

I do hereby consent to such treatment by the authorized personnel of Align Physical Therapy Group as may be dictated by prudent medical practice by illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. A copy of this assignment shall be considered as effect and valid as the original.

_____ _____

Authorized Signature (please print name if other than patient) Date

PATIENT CONFIDENTIALITY AND PRIVACY GUIDELINES

I hereby give my consent for Align Physical Therapy Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Align Physical Therapy Group describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Align Physical Therapy Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to alignphysicaltherapyreno@gmail.com or a copy is available to me at the time of my appointment.

With this consent, Align Physical Therapy Group may call or mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that Align Physical Therapy Group restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Align Physical Therapy Group to use and disclose my PHI to carry out TPO.

_____ _____

Authorized Signature (please print name if other than patient) Date