

PHYSICAL THERAPY OF COLLEYVILLE PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	Account # <input style="width: 80%;" type="text"/>	Account Type <input style="width: 80%;" type="text"/>	Office # <input style="width: 80%;" type="text"/>
First Name _____ MI _____ Last Name _____ Address _____ City _____ State _____ Zip _____		Date of Injury/Onset _____ Today's Date _____ Date of Birth _____ Age _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W Home Phone _____ Work Phone _____ Cell Phone _____ Injury Area _____ Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No If Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other Nature of Accident _____ SS# _____	
Responsible Party _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Relationship to Responsible Party _____			
Employer _____ Address _____ City _____ State _____ Zip _____		Occupation _____ Contact at Employer _____	
Referring Physician _____		Phone Number _____	
Primary Insurance _____ Group # _____ ID # _____ Insured Employer _____ Relationship to Insured _____		Insured Name _____ Address _____ City _____ State _____ Zip _____ Phone _____ Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Second Insurance _____ Group # _____ ID # _____ Insured Employer _____ Relationship to Insured _____		Insured Name _____ Address _____ City _____ State _____ Zip _____ Phone _____ Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Emergency Contact _____		Daytime Phone Number _____	
Are you receiving or have you recently received home health services? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you receiving or have you recently received other therapy services? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please initial: _____	
<p>CONSENT TO TREATMENT: I consent to rehabilitation and related services at PHYSICAL THERAPY OF COLLEYVILLE. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____</p>			
<p>TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____</p>			
<p>LIABILITY: I know and agree that PHYSICAL THERAPY OF COLLEYVILLE is not responsible for loss or damage to personal valuables. _____</p>			
<p>WAIVER AND RELEASE: I hereby release, discharge and acquit PHYSICAL THERAPY OF COLLEYVILLE, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____</p>			
<p>AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to PHYSICAL THERAPY OF COLLEYVILLE and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____</p>			
<p>NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____</p>			
I certify that all of the information provided herein is true and correct.			
Patient/Guardian Signature _____		Witness Signature _____	