

GREATER BRUNSWICK PHYSICAL THERAPY PATIENT INTAKE AND CONSENT FORM

Internal use only: _____ Account# _____ Account Type _____ Office# _____

First Name _____ MI _____
 Last Name _____
 Address _____

 City _____ State _____ Zip _____

Date of Injury/Onset _____ Today's Date _____
 Date of Birth _____ Age _____
 Sex: M F Marital Status: S M D W
 Home Phone _____
 Work Phone _____
 Cell Phone _____

Responsible Party _____
 Address _____
 City _____ State _____ Zip _____
 Phone Number _____
 Relationship to Responsible Party _____

Injury Area _____
 Accident Related: YES NO
 If Accident: Auto Work Other
 Nature of Accident _____

Employer _____
 Address _____
 City _____ State _____ Zip _____

SS# _____
 Occupation _____
 Contact at Employers _____

Referring Physician _____
 Emergency Contact _____

Primary Physician _____
 Daytime Phone _____

Are you receiving or have you recently received home health services? Yes No
 Are you receiving or have you recently received other therapy services? Yes No Please Initial: _____

CONSENT TO TREATMENT: I consent to services at Greater Brunswick Physical Therapy. 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. _____

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 such treatment and waive any claim I may have resulting from failure to do so. _____

LIABILITY: I know and agree that Greater Brunswick Physical Therapy is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Greater Brunswick Physical Therapy, its 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. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Greater Brunswick Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and 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. _____

CANCELLATION/NO SHOW POLICY: Our cancellation/no show policy is designed to improve the quality of care of our present patients and allow us to see new patients who need services. Any combination of four same day cancellations and or no shows will result in discharge from physical therapy. Your Physician will be contacted to inform him/her of the reason for discharge. Additionally, if more than one appointment is missed due to no shows, a \$30.00 fee will be charged for each subsequent no show. This fee is not covered by insurance. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. I certify that all of the information provided herein is true and correct. _____

Patient/Guardian Signature _____ Witness Signature _____