Patient Intake Form

Patient Name_____ Birth date_____/_____/_____ Male ____ Female ____

Address_____ City_____ State_____ Zip code_____

Home phone ( )_____ Cell phone ( ) _____ Work phone ( )_____

SSN _____ ***E-mail** _____

Diagnosis/problem _____ Onset of injury _____

Occupation _____ Employer _____

CANCELLATION POLICY: Patients will be charged $50 for missed physical therapy appointments or appointments cancelled without 24 hour notice. The cancellation fee will be waived if the cancelled appointment is rescheduled for the same week as the cancellation.

Physician Information

Referring physician _____ ph ( ) _____ fax ( ) _____
Address _____

Primary care physician _____ ph ( ) _____ fax ( ) _____
Address _____

Insurance Information

Subscribers name _____ Subscribers date of birth _____
Relationship to patient _____

Were you in a car accident? ☐yes ☐no Auto claim # _____ Contact person _____

Were you hurt at work? ☐yes ☐no WC claim # _____ Contact person _____

Is this a personal injury case involving an attorney? ☐yes ☐no
If yes, please provide the attorney name & address _____ ph ( ) _____

How did you hear about Ascent Physical Therapy? _____

I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the supplier for services rendered. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the entire bill.

Signed _____ Date _____/_____/_____

For Office Use Only

Primary Insurance _____ Phone _____
Member # _____ Group#_____ Co-pay _____
Deductible _____ Deductible met_____ % Insurance covers_____ %Patient covers_____
Max # of visits per year? _____/Used to date_____ Yearly dollar limit for PT visits _____/Used to date_____
Effective date of coverage_____ Date verified _____ Time _____ Contact person _____

Required? : ☐ Prescription from physician ☐ Letter of medical necessity Pre-Certification required? _____

Secondary Insurance _____ Phone _____
Member # _____ Group#_____ Co-pay _____
Deductible _____ Deductible met_____ % Insurance covers_____ %Patient covers_____
Max # of visits per year? _____/Used to date_____ Yearly dollar limit for PT visits _____/Used to date_____
Effective date of coverage_____ Date verified _____ Time _____ Contact person _____

Required? : ☐ Prescription from physician ☐ Letter of medical necessity Pre-Certification required? _____
