

# Patient Intake Form

DATE OF INTAKE: \_\_\_\_\_ DATE SCHEDULED: \_\_\_\_\_

Called after Initial Evaluation: \_\_\_\_\_ Attire \_\_\_\_\_ Paperwork \_\_\_\_\_ Payment \_\_\_\_\_ Late/CXL Policy \_\_\_\_\_ Early \_\_\_\_\_

\*Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male or Female  
(As appears on insurance card with middle initial)

\*Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\*Phone #1 (Circle one Home, Cell, Work) Phone #2 ( Home, Work, Cell) Email Address (Important)  
( \_\_\_\_\_ ) ( \_\_\_\_\_ ) \_\_\_\_\_

\*What are you seeking treatment for?(Where & when did it start) \_\_\_\_\_

\*How did you hear about or find our clinic? Doctor: \_\_\_\_\_ Friend/Family: \_\_\_\_\_  
Advertisement: \_\_\_\_\_ Web: \_\_\_\_\_ Phone Book: \_\_\_\_\_ Other : \_\_\_\_\_

\*Social Security # \_\_\_\_\_ Are you: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

\*Emergency Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
( \_\_\_\_\_ )

\*Is condition related to: Work \_\_\_\_\_ Auto Accident (State \_\_\_\_\_) Personal Liability \_\_\_\_\_ None \_\_\_\_\_

\*The date of my injury was \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Required for Work Comp, Auto or Personal Liability Injuries)

\*Work Status: Currently Employed \_\_\_\_\_ Retired \_\_\_\_\_ Disabled ( \_\_\_\_\_ Total or \_\_\_\_\_ Temporary) Student ( \_\_\_\_\_ P/T \_\_\_\_\_ F/T)

\*Occupation \_\_\_\_\_ Employer & Phone Number \_\_\_\_\_

\*Name of Primary Care Physician & Phone Number: \_\_\_\_\_

\*Name of Referring Physician and Phone Number: \_\_\_\_\_ N/A

\*Would you like your records sent to the above physicians? Referring Physician \_\_\_\_\_ PCP \_\_\_\_\_ Both \_\_\_\_\_ Neither \_\_\_\_\_

## Payment Options

### Private Pay

\_\_\_\_ I am paying by cash, check or credit card at the time of service to take advantage of the cash pay discount.

### Health Insurance

Primary Insurance Company: \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
Plan ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
Plan ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

### Worker's Comp Insurance

Primary Insurance Company: \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
Claim Number \_\_\_\_\_ Name of Adjuster \_\_\_\_\_  
Employer insuring the Claim & Phone: (same as above \_\_\_\_\_) \_\_\_\_\_

### Auto Insurance

\_\_\_\_ I have **Med Pay Insurance** \_\_\_\_\_ Phone: \_\_\_\_\_ Cl# \_\_\_\_\_  
Amount\$ \_\_\_\_\_ Adjuster \_\_\_\_\_ Adjuster's Phone \_\_\_\_\_

\_\_\_\_ I have an **Attorney** and would like to pay upon the time of settlement.

Attorney's Name \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

## **PATIENT RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS**

**NOTICE OF PATIENT INFORMATION PRACTICES PER LEGAL DUTY:** Sport and Spine Physical Therapy, Brighton, PLLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein. If you have questions regarding the Confidentiality Agreement or the Patient Information Policies, please bring them to our attention.

I hereby authorize Sport and Spine Physical Therapy, Brighton, PLLC to release to my insurance company or its representatives, and other health care professionals working on my medical case, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I also authorize and request my insurance company to pay directly to the above named physical therapy clinic the amount due for services rendered. I understand that it is my responsibility to call my insurance company to verify coverage for physical therapy through my policy, and agree to pay any co-pays, deductibles, and any other portions that my insurance company will not pay. If I cancel my appointment with less than 24 hour notice I will be charged, and agree to pay, for the visit.

In the event payment is not received within 30 days of statement date, my account will be subject to an interest charge of 1 ½% per month. If no payment is made, my account will be placed with a collection agency for the amount due as well as collection fees. I understand that Sport and Spine Physical Therapy, Brighton, PLLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to designate individuals to whom my information can be released. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sport and Spine Physical Therapy, Brighton, PLLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sport and Spine Physical Therapy, Brighton, PLLC's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I also authorize Sport and Spine Physical Therapy, Brighton, PLLC to use my protected health information for Sport and Spine's targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

Sport and Spine Physical Therapy, Brighton, PLLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Sport and Spine Physical Therapy, Brighton, PLLC may use your personal health information to contact you to provide appointment reminders, newsletters, or information about treatment alternatives or other health related benefits that could be of interest to you.

Sport and Spine Physical Therapy, Brighton, PLLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for billing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Sport and Spine Physical Therapy, Brighton, PLLC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Sport and Spine Physical Therapy, Brighton, PLLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT'S INDIVIDUAL RIGHTS:** You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Sport and Spine Physical Therapy, Brighton, PLLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

**CONCERNS AND COMPLAINTS:** If you are concerned that Sport and Spine Physical Therapy, Brighton, PLLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Sport and Spine Physical Therapy, Brighton, PLLC health information practices or if you have a complaint, please contact the office manager at (303) 655-8699.

**BENEFITS:** As a courtesy to our patients we will verify benefits, however the benefits quoted are not a guarantee of payment. It is the patient's responsibility to verify and get a thorough understanding of their medical benefits specific to Sport & Spine PT. The patient is responsible for all charges not reimbursed by their insurance carrier including but not limited to coinsurance, deductibles, and any charges associated with collection activity; billing fees for co-pays not paid on the date of service and any portion of the account that exceeds 30 days past due should you fail to reimburse Sport & Spine PT for amounts due for services rendered. In the event of default, you agree to pay all collection agency fees in the amount equal to 40% of the outstanding balance, and reasonable attorney fees.

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**Patient /Parent or Guardian (Please Print and Sign)**

**Date**

I HAVE READ AND UNDERSTAND ALL OF THE POLICIES PERTAINING TO PATIENT INFORMATION PRACTICES AND I AUTHORIZE SPORT AND SPINE PHYSICAL THERAPY, BRIGHTON, PLLC TO RENDER THE APPROPRIATE PHYSICAL THERAPY TREATMENT ACCORDING TO REASONABLE AND CUSTOMARY PHYSICAL THERAPY PRACTICE. **\*If you would like a copy of your signed notice, please request such at the front desk.**