PETERSEN PHYSICAL THERAPY
Intake Form 1 - General Information

Patient Name: _____ **DOB:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

How did you hear about *Petersen Physical Therapy*?

_____

A. MOTOR VEHICLE RELATED
Are your injuries due to a motor vehicle or other type of accident? Yes _____ **No** _____ **Initials** _____

B. PATIENT INFORMATION – To Be Completed in the Office

I have verified that my information on the accompanying patient information page is correct.

Signature: _____ Date: _____

C. EMERGENCY CONTACT / PERSONAL REFERENCE OUTSIDE THE HOME

Name: _____ Relationship: _____

Home Telephone: _____ Cell Phone: _____

D. RELEASE OF / REQUEST FOR INFORMATION AUTHORIZATION

Petersen Physical Therapy may disclose all or part of the patient's medical and/or financial records to your insurance carrier, to referring physicians, and to other healthcare providers responsible for providing continued patient care. We may request health information related to your physical therapy.

Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

G. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for *Petersen Physical Therapy.*

Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

Do you wish to identify anyone else who may receive information regarding your protected health information?

Name of Person/Organization: _____

Name of Person/Organization: _____

Signature: _____ Date: _____

THIS NOTICE OF PRIVACY AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

PETERSEN PHYSICAL THERAPY

Intake Form 2 - Financial Agreement for Services Rendered

Patient Name: _____ **DOB:** _____ **Social Security #:** _____

Please initial each bullet and sign below:

INSURANCE VERIFICATION

_____ We will try to contact your insurance carrier to verify your physical therapy benefits as a courtesy to you. While we do our best to obtain accurate insurance information on your behalf, your insurance company makes no promise of the information being accurate and/or final.

_____ You are ultimately responsible for knowing your benefits and we recommend that you call your insurance company as well to understand what your physical therapy benefits are.

_____ It is your responsibility to notify us of any changes to your benefits during the course of your treatment with *Petersen Physical Therapy.*

_____ In most cases your insurance will require a current prescription in order to consider physical therapy services.

_____ If you have secondary or supplemental coverage, please notify us.

_____ If you are being seen due to an auto related accident, please notify us.

_____ *Petersen Physical Therapy* is not a durable medical equipment provider. Your insurance may not cover items such as foot orthotics, braces, and various pieces of exercise equipment when obtained from us. If you choose to purchase directly from us, payment for these items may be your responsibility.

_____ If your coverage is Medicare, we are required to notify you in advance if any of our services may not be covered services. You will be given the option to accept or deny. An advanced beneficiary notice form must be completed to receive items or services that may not be covered by Medicare.

A representative of *Petersen Physical Therapy* has described to me my insurance benefits and payment arrangements, and has answered my questions.

Signature: _____ Date: _____

FINANCIAL AGREEMENT

_____ I understand that *Petersen Physical Therapy* is billing my insurance as a courtesy.

_____ I understand that the quoted insurance benefits are not a guarantee of payment by my insurance company and that the insurance carrier determines payment at the time of processing.

_____ I authorize my insurance company or payor to pay medical benefits directly to *Petersen Physical Therapy* for services rendered to me.

_____ I agree to pay as services are rendered for the estimated patient responsibility. I also agree to pay for items such as medical supplies as these generally are not covered by my insurance.

_____ I understand and agree that all services rendered are ultimately my financial responsibility.

IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT'S BILL AND THEREFORE RESPONSIBLE FOR ANY AMOUNTS UNPAID BY THE INSURANCE COMPANY OR PAYOR.

Please Note: *Petersen Physical Therapy* reserves the right to charge $25.00 for missed appointments or appointments that are cancelled in less than 24 hours from your scheduled time.

Signature: _____ Date: _____

Petersen Representative: _____ Date: _____

- **Petersen Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.**