



PATIENT INTAKE FORM
PLEASE FILL OUT COMPLETELY AND CLEARLY

Date: Patient's Legal Name:

Nickname: [] Male [] Female DOB: SSN:

Mailing Address: City/State/Zip:

Main Phone: Cell: Email:

Primary Insurance: Secondary Insurance:

Primary Insured Name: Relationship to Patient:

Primary Insured DOB: Primary Insured SSN:

Employer: Occupation:

Address: Phone #:

Have you had ANY therapy in the past 12 month? [] PT [] OT [] Speech [] Chiropractic [] Cardiac/Pulmonary or [] No
If yes, when was it? How many visits? Was it at our clinic [] Yes [] No Was it for same injury? [] Yes [] No

Referring Physician: Phone:

Emergency Contact: Phone: Relationship:

WORKER COMPENSATION OR MEDICAL INFORMATION
Date of injury: Claim #
Insurance Company: Phone #:
Address: City/State/Zip:
Adjuster/Case Manager: Phone #:
Is an attorney involved? [] Yes [] No-Attorney Name/Phone #:

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by AccelAbility Balance & Therapy. Further, I authorize AccelAbility Balance & Therapy to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by AccelAbility Balance & Therapy, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill. I agree to furnish proof if another party is responsible for the payment. I request any payments of authorized insurance benefits for me or on my behalf be paid directly to AccelAbility Balance & Therapy. I authorize AccelAbility Balance & Therapy to file my insurance with the insurance company listed above. I authorize the release of any medical information to AccelAbility Balance & Therapy to process this and any future claims. I understand that I am responsible for all reasonable charges incurred if this amount is turned over to an attorney for collection.

NOTICE OF INFORMATION PRIVACY PRACTICES

I acknowledge that I have been shown the posted Notice of Information Practices by AccelAbility Balance & Therapy. I certify that I understand these rights as set forth.

Signature of Patient: Date:

Information below is required for treatment of a minor or a patient who does not have their own power of attorney.

Name of Parent or Legal Guardian: Signature: