

Patient Intake Information



Patient Information:

First Name: _____ M.I. _____ Last Name: _____ DOB: _____
SSN: _____ Identity Pronouns: _____ Legal Gender Male Female
Mailing Address: _____ City: _____ State: _____ Zip: _____
E-mail: _____ Statement Preference Email (Default) Mail Both
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Describe the body part(s) requiring physical therapy: _____ Referring/Primary Provider: _____
Are you being seen by another therapy provider: No Yes if yes, who? _____

Insurance/Financial Information:

Guarantor (Financially Responsible Party): Relationship to Patient: Self Mother Father Other _____
First Name: _____ M.I. _____ Last Name: _____ DOB: _____
SSN: _____ Is the guarantor's mailing address same as patient Yes No If no,
Mailing Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

This information is required even with a copy of your card(s) on file

Primary

Insurance: _____
ID#: _____ Grp #: _____
Policy Holder: _____
Date of Birth: _____ SSN: _____
Employer/Union: _____
Relationship to patient: Self Spouse Parent Other _____

Secondary

Insurance: _____
ID#: _____ Grp #: _____
Policy Holder: _____
Date of Birth: _____ SSN: _____
Employer/Union: _____
Relationship to patient: Self Spouse Parent Other _____

INJURY/ACCIDENT/WORKER'S COMPENSATION

Is your visit related to an injury or accident? No Yes If yes, is there Medpay? No Yes If yes, what is the amount \$ _____
Employer or Policy Holder: _____ Payor Name: _____
Adjuster's Name: _____ Adjuster's Phone & Extension: _____
Address: _____ City: _____ State: _____ Zip: _____
Claim/Case ID: _____ Injury Date: _____ Injury State: _____

Emergency Contacts/Personal Health Information (PHI):

If selected, I authorize the release of the selected information to the individual listed. I understand that only the individual listed may obtain the selected information regarding the patient (including appointment scheduling/information & billing information). If nothing is selected the individual listed will be listed as emergency contact only and will be unable to receive any information.

Name: _____ Phone: _____ Relationship: _____
 Appointment Reminders/Changes Account Payment/Balances All General Healthcare Information Emergency Contact
Name: _____ Phone: _____ Relationship: _____
 Appointment Reminders/Changes Account Payment/Balances All General Healthcare Information Emergency Contact

How did you hear about us?

Employee Workshop APU Athlete/Event Facebook Patient Friend Google Provider Other _____

I agree that this information is true and accurate to the best of my knowledge. I understand it is my responsibility to keep my information up-to-date.

Signature: _____ Relationship to Patient: _____ Date: _____

Patient Name: _____

Date of Birth: _____

Authorizations, Consents & Acknowledgements

Insurance Options: Initial only one option in this box. We cannot choose the option for you.

_____ OPTION 1. I want to be seen by a provider at Advanced Physical Therapy. I want Advanced Physical Therapy to bill my insurance(s).

_____ OPTION 2. I want to be seen by a provider at Advanced Physical Therapy. I want Advanced Physical Therapy to bill the following insurance(s): _____. However, I do not want Advanced Physical Therapy to bill the following insurance(s): _____.

_____ OPTION 3. I want to be seen by a provider at Advanced Physical Therapy. I do not want Advanced Physical Therapy to bill any of my insurance(s). I will be considered a cash pay patient.

_____ OPTION 4. I do not want to be seen by a provider at Advanced Physical Therapy at this time.

Please initial each section to indicate that you have read and understand the information provided.

_____ I authorize Advanced Physical Therapy (APT) to examine the patient, administer treatment as necessary, and perform procedures that are deemed therapeutically or diagnostically necessary.

_____ I hereby acknowledge receipt of APT's full consent and notice of privacy practices and protocol.

_____ I understand that APT verifies coverage, plan limits and authorization needs. However, it is my responsibility to know my own insurance policy, coverage, limitations, and annual & benefit maximums.

_____ I understand that any cost estimates provided by APT are not exact and that final responsibility is determined after my insurance company processes the claim.

_____ I understand that a valid payment card must be kept on file and that payment is due at the time of service, including any applicable deductibles, copayments, and coinsurance. I consent to the following: (1) my card will be automatically charged for cancellation and no-show fees; (2) my card will be charged at the time of service for deductibles, copayments, and coinsurance; and (3) any patient-responsibility balance remaining on my account for 30 days will be automatically charged to my card. *Your financial information will be kept securely in our HIPAA-compliant database and used only with secure systems associated with our database.*

_____ I understand that a 3% surcharge may be applied to credit or debit card payments (excluding HSA/FSA payments). Cash, check, or money orders will not incur this surcharge.

_____ I understand that 24-hour notice is required for cancellations. A \$50.00 fee will be charged for no-shows or cancellations with less than 24-hour notice. This fee is not covered by insurance and will be billed directly to the guarantor.

_____ I understand that frequent no-shows or same-day cancellations constitute non-compliance with the attendance policy and will result in removal from the schedule. The patient will be placed on the Same-Day Call List if this occurs. Non-compliance is defined as two or more consecutive no-shows or repeated same-day cancellations.

By signing below, I acknowledge that I am responsible for adhering to all Advanced Physical Therapy's policies. I understand that crossing out or failing to initial any section does not waive my responsibilities or exempt me from my compliance with these policies, including those related to attendance, participation, and financial obligations.

Signature: _____ Relationship to Patient: _____ Date: _____



Patient Name: _____

Date of Birth: _____

Pay-at-Time-of-Service/Card-on-File Agreement

Your financial information will be kept securely in our HIPAA-compliant database and used only with secure systems associated with our database.

APT will keep your credit card information on file solely for the purpose of paying your estimated balance at the time of service. This balance is based on each day's expected charges relative to your health plan's benefits for physical therapy. Please note that health plan benefits are not calculated in real time, so the balance provided at the visit is only an estimate. Once your insurance has processed the claim, any overpayment will remain on account until you are discharged from therapy, at which point any remaining credit will be refunded to you by check.

CARD INFORMATION

Name on Card: _____ Card Type: Visa MC Discover Amex

Card Number: _____ Expiration Date: _____ Code: _____

Billing Zip Code: _____ Cardholder's Phone: _____

Patient/Guarantor Signature: _____ Date: _____

Patient/Guarantor Printed Name: _____

By providing my card information, I authorize Advanced Physical Therapy to automatically charge my card for: cancellation and no-show fees; at the time of service for deductibles, copayments, and coinsurance; and any patient-responsibility balances remaining on my account for 30 days. I understand I am responsible for keeping my card information updated.

Cardholder Signature: _____ Date: _____

Cardholder's Printed Name: _____ Relationship to Patient: _____

APT CLINIC USE ONLY

Facility: _____ Chart #: _____

If applicable, PHI on file: Yes No N/A

Entered on: _____ Entered by: _____



Name: _____

Appointment Preference Times

Select your preferred appointment day(s) and time(s)

Day/Times	Before 8am	8am-Noon	Noon-3pm	3pm- 5pm	After 5pm
Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>