Attachment B1.003A
Attachment M7.005C

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office#

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex oM oF Marital Status oS oM oD oW

_____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Cell Phone _____

Responsible Party _____ E-mail _____

Address _____ Injury Area _____

City _____ Accident Related: oYes oNo

Phone Number _____ If Accident: oAuto oWork oOther

Relationship to Responsible Party _____ Nature of Accident _____

SS# _____

Employer _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: oM oF

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: oM oF

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? oYes oNo

Are you receiving or have you received other therapy services? oYes oNo

(Continued on next page)

Please Initial Each
as Applicable:

PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	A/C#	Name	A/C Type	Office#

CONSENT TO TREATMENT: I consent to rehabilitation and related services at
In so doing, I understand, acknowledge and affirm that such rehabilitation and
involve bodily contact, touching and/or direct contact of sensitive nature.

_____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY: I know and agree that is not responsible for loss or valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit ,
representatives, affiliates, employees, or assigns, of and from any and all liability, claim, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to or allow emergency and or medical services, including but not limited to ambulance Medical Technician, physician or urgent care services.

_____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____